UNIVERSITY OF PENNSYLVANIA

FINANCIAL ASPECTS OF STATE CARE OF THE INSANE IN NEW YORK

BRADFORD W. WEST

A THESIS

IN POLITICAL SCIENCE

PRESENTED TO THE FACULTY OF THE GRADUATE SCHOOL IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

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TABLE OF CONTENTS

PAGE

I

Introduction 5

II

Reimbursement 19

III

Aliens, Non-residents, and the Foreign-born 54

IV

The Employment of Insane Patients Considered as a Means of Reducing Public Expenditures for their Care 71

V

The Financial Aspects of Insanity Prevention and of the Early Discharge or Parole of Patients 84

VI

Conclusions 102

Bibliography 106

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I

Introduction

A. *The Increasing Frequency of Insanity*

The number of patients in institutions for the insane in New York State has doubled in the twenty-five years since 1904. This increase of mental patients has been at a much faster rate than the increase of the population of the state. Thus in 1904 the number of patients per 100,000 residents of the state was 339.7; in 1928 it had become 451.0. Moreover, this trend appears to be permanent.[1]

The same trend is noticeable throughout the country. The federal census of "Patients in Hospitals for Mental Disease, 1923" gives the figures in Table I. These figures suggest two questions. Why is the ratio of patients to population increasing so rapidly, and why is the ratio so much higher in New York than in the whole United States?

TABLE I

Patients in Hospitals for Mental Disease, 1923[2]

Year	Number of Patients	Rate per 100,000 of Population
1923	267,617	245.0
1910	187,791	204.2
1904	150,151	183.6
1890	106,485	170.0

No one answer to the first of these questions is complete. The increase in institutional population is partly an indication that a larger proportion of the mental patients in the country are being institutionalized than formerly. On the other hand there

[1] For complete statistics as to the numbers of patients in institutions for the insane in New York, and ratios of patients to population, 1889–1928, see the *Fortieth Annual Report of the Department of Mental Hygiene*, pp. 203–204.

[2] Department of Commerce, Bureau of the Census, *Patients in Hospitals for Mental Disease*, 1923, p. 11.

is general agreement among psychiatrists that mental disease is becoming more common. But why is it that a larger proportion of mental patients are being institutionalized, and why is mental disease becoming more common? These are the really important, fundamental questions.

The principal reason why relatively more patients are being cared for in hospitals is that for a considerable number of years the states have been increasing and improving their hospital facilities for mental patients. As the hospitals become more nearly adequate they tend to draw in more and more of the patients who would otherwise shift for themselves, be cared for by their relatives, or in poorhouses. This part of the increase is but the natural and desirable fulfillment of the policy of providing hospital care for all mental patients who require it.

Another reason for the increase is the change of the public attitude toward hospitals for the mentally diseased. In recent years much publicity has been given the fact that these institutions are hospitals in fact as well as in name. As a result of this there is not the same stigma attaching to commitment to a state hospital that there was when insane asylums of the typical sort were merely safe places of detention for the dangerously demented, from which there was practically no hope of discharge. The nature of early American provision for the insane is evident from the following quotation from a New York statute of 1788:

"Whereas, There are some persons who, by lunacy or otherwise, are furiously mad or are so far disordered in their senses that they may be dangerous to be permitted to go abroad; therefore, Be it enacted, That it shall and may be lawful for any two or more justices of the peace to cause such person to be apprehended and kept safely locked up in some secure place, and, if such justices shall find it necessary, to be there chained . . ."[3]

In the one hundred and forty years since this statute was adopted the custodial aspect of the institutions for the insane has been minimized as much as possible in most states. The

[3] Quoted in Hurd, H. M., ed., *The Institutional Care of the Insane in the United States and Canada*, Vol. III, p. 111.

resulting stress upon the therapeutic function of the hospitals, together with realization that mental disease is not necessarily hopeless, has undoubtedly led to the commitment of many patients who formerly would have been maintained by their families. Coupled with this is the general trend of the times to make more common use of hospitals of all kinds.

A third reason for the disproportionate increase of mental hospital patients is that there is each year a growing accumulation of chronic patients in the hospitals,—an accumulation which is more noticeable the older the institution. This accumulation is largely due to the fact that schizophrenia, the commonest of the psychoses, requires hospitalization at a comparatively early age and is among the psychoses most resistant to successful treatment.

There are at least two factors which contribute to the increasingly common incidence of mental disease. The first of these is the increase in the average duration of life. Hospital statistics covering a period of many years show that the average age of patients at the time of their admission is quite advanced. According to the federal census in 1923, the average age of the patients admitted to hospitals for mental diseases for the first time during 1922 was 42.6 years. Obviously mental diseases generally become acute during maturity or old age. It follows that if a larger proportion of the population live to reach this time of life there are likely to be relatively more cases of mental illness.

It is also adduced that the increasing complexity of modern civilization is responsible for the development of more cases of mental disease than would develop under simpler conditions of life. Hospital statistics seem to support this contention. Patients from rural districts constitute a considerably smaller portion of the population of those districts than do patients from cities of city population. Consequently with the shift of population from country to city and with the increasing complexity of life everywhere, it would appear that there is a correlation of these facts with the growing frequency of mental illness.

There is an additional bit of evidence which supports both of these contentions. The percentage of the patients in the state hospitals who are foreign-born is much larger than the percentage

of the same class in the total population of the country. Doubtless this is partly due to the poor quality of the immigrants. But it seems to be in part due to the extremely difficult task of the foreigner of adjusting himself to new ways of living among strange people whose language and customs are different from those to which he is accustomed. It is also due in part to the fact that the average age of immigrants is considerably higher than the average age of the native-born population.

The same reasons which explain why the insane population is increasing so rapidly explain why the ratio of insane to total population is so much higher in New York than generally throughout the country. In the first place, New York is an old state and was one of the first to provide for the treatment of the insane on a large scale. As a result there is an unusually large accumulation of chronic patients in her hospitals. In the second place, provision for the care and treatment of the insane is much more complete in New York than in many states. The standards of care are high and it follows that there is a corresponding tendency for patients to avail themselves of it. Finally, New York has a predominantly urban population and an exceptionally large number of foreign-born residents. On June 30, 1928, for instance, 41.6 per cent of the patients on the books of the civil state hospitals were foreign-born.[4] For all of these reasons it is to be expected that New York would have a larger ratio of patients in state hospitals than most other states. This conclusion is substantiated by the fact that Massachusetts, which was shown by the census of 1923 to be the only state having a higher ratio of mental patients to population, is similar to New York in all of the above-mentioned respects.

B. *The Cost of Insanity*

This great increase in mental hospital population represents an immense economic loss,—a loss which takes two forms. First there is the direct outlay by the state for hospitals, clinics, and associated facilities. Of the same nature are the expenditures of private and semi-private institutions engaged in the same sort

[4] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 158.

of work. Considering the increase in hospital population in recent years it would not be surprising to find that the cost of maintenance has been increasing proportionately. As a matter of fact the state is not only caring for more patients but it is spending much more per patient. Table II shows the amount of the state's expenditures in some typical years.

While Table II shows the actual expenditures for the state hospital system in the specified fiscal years it does not give a complete picture of the economic loss attributable to insanity. A more nearly accurate idea of the size of this loss is given by Dr. Horatio M. Pollock, statistician of the Department of Mental Hygiene, in an article entitled "Economic Loss on Account of Hospital Cases of Mental Disease and Associated Physical Disorders in New York State, 1928."[5] Table III, Cost of maintenance of patients in institutions for mental disease in New York State, fiscal year ended June 30, 1928, summarizes the conclusions reached in the first part of this article.

This article itemizes the three principal cost items which go to make up the total cost of maintenance of the three classes of hospitals for the insane in the state, the civil state hospitals, the two state hospitals for the criminal insane and the licensed institutions. Table II dealt only with the civil state hospitals. The principal merit of Table III is that it brings out the importance of the investment charge as an item of cost in maintaining hospitals for the insane. Dr. Pollock figured the amount of this as follows:

" . . . Judging, however, from the cost of the new units at Kings Park, Creedmoor, and Rockland State Hospitals, the present average outlay for plant and equipment per patient is approximately $4,000. We have therefore used this figure in computing per capita investment charges in both groups of state hospitals. The capital outlay of the licensed institutions per patient is estimated to be $6,000."[6]

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[5] This article is published in the April, 1929 issue of the *Psychiatric Quarterly*, pp. 186–195, and in reprint form. Table III is at p. 190.

[6] *Op. cit.*, p. 188.

TABLE II

EXPENDITURES FOR THE NEW YORK STATE HOSPITALS

YEAR	EXPENDITURES
1928	$24,642,699.42
1927	25,953,709.27
1926	21,809,373.57
1925	19,457,593.00
1924	17,823,792.08
1919	11,985,695.55
1914	7,403,970.08
1909	6,444,009.11

TABLE III

COST OF MAINTENANCE OF PATIENTS IN INSTITUTIONS FOR MENTAL DISEASES IN NEW YORK STATE, FISCAL YEAR ENDED JUNE 30, 1928

	I	II	III	IV
Maintenance and operation	$23,766,485	$17,687,939	$798,546	$5,280,000
Investment charge	13,824,160	12,234,040	481,320	1,108,800
General administration	480,520	436,930	17,190	26,400

I. Totals.
II. Civil state hospitals, 43,639 patients.
III. State hospitals for criminal insane, 1,719 patients. (Note: the cost of these hospitals is not included in Table II.
IV. Licensed institutions, 2,640 patients.

On these estimates of the outlay per patient 5 per cent was allowed for interest and 2 per cent for depreciation. The total investment charge thus computed amounted to $13,824,160. In the two groups of state hospitals this charge is equal to approximately three-fourths of the annual outlays for maintenance and operation. It is, therefore, a by no means negligible item to be considered in any estimate of the cost of caring for the insane.

Little need be said of the other items in Table III. All of the items in column IV (cost of licensed institutions) are Dr. Pollock's estimates. The items for maintenance and operation in columns II and III are the actual expenditures by the state on this account. The items for general administration include the actual expenditures of the Department of Mental Hygiene on this account plus a small estimate to cover the expenditures of

other state departments on account of mental disease. As said before, the principal value of these figures is that they indicate in a rough fashion that a major part of the cost of providing for the insane is the investment charge. They also show the approximate total cost for 1928 of providing care for the 47,998 patients then being cared for.

The second type of loss attributable to insanity is the loss of potential earning power of the patients. For the group of patients admitted to the hospitals for the first time during the year ending June 30, 1928, Dr. Pollock estimates that the loss of earning power amounted to $91,907,470.[7] Though this figure is but an approximation it has been calculated with sufficient care to make it acceptable as evidence that the cost of caring for the insane is a minor fraction of the loss due to insanity. It makes more obvious the desirability of taking preventive measures, for even though this loss does not all come out of taxes it does have to be borne by the people of the state. Moreover, indirectly part of this loss of earning power does have to be made up out of taxes when the dependents of mental patients require public support. There are enough dependents of this sort to make a heavy drain on the resources of public and private charities.

C. *The Need for State Provision for the Insane*

It has been shown above (Table II) that in recent years the State of New York has spent close to twenty-five million dollars a year to provide for the care and treatment of the mentally ill. There are two factors which combine to make this large expenditure necessary and proper. First, there is the long-recognized fact that many insane persons must be confined lest their being at large result in harm to themselves or danger and inconvenience to others. This fact has been recognized in New York for a great many years, as is shown by the quotation (on page 6) from a statute of 1788. Indeed, it is such an obvious fact that it is likely to be overstressed.

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[7] The method by which this calculation was made is fully described in Pollock, *op. cit.*, pp. 190–195. Briefly it was made by multiplying the estimated net economic value of average persons of the same age by the estimated per cent of value lost on admission.

Secondly, it is now demonstrable that many insane persons are so benefitted by proper treatment as to make possible their return to society, either with or without further guardianship. Consequently, it is now recognized that the primary function of institutions for the care of the insane is to afford treatment designed to further the recovery of patients in so far as this is possible. In the New York state hospitals the custodial aspect of the institutions, though a very necessary aspect, is most decidedly a secondary consideration. This situation has come about, however, only after many years of development since the days when insane persons were confined in jails and poorhouses without segregation from other inmates and in most wretched circumstances.[8] Under those early conditions commitment for insanity was nearly always a life sentence, the recovery of the patient being made virtually impossible under the treatment which was accorded him.

No one will deny that it is good for the individual and for society to afford therapeutic facilities to everyone who is sick and whose condition is likely to be improved by treatment. Relatively few sufferers from mental illness could pay the price of treatment at privately-owned profit-making institutions. The remainder must go untreated or else be cared for in institutions provided at public expense. Since the state must in any event provide quarters where the troublesome among the poor and indigent insane may be kept in custody, it is a logical step to make these institutions hospitals.

The provision of care and treatment for the insane rather than mere custody, in addition to being of great social value, has the added advantage of not costing the state anywhere near as much as it appears to on first sight. Of course, for a given number of patients the cost of treatment is considerably greater than the cost of confinement alone. But treatment results in improvement in the condition of many patients to the point where they may be discharged or paroled much sooner than they would otherwise leave state care. Thus in the fiscal year ending June 30, 1928, there were discharged from the civil state hospitals,

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[8] Hurd, *op. cit.*, fully describes these early conditions.

exclusive of discharges by transfer to other hospitals, 4,458 patients. Of these, 1,712 were discharged as recovered, 1,067 as much improved, 990 as improved, 559 as unimproved, and 90 as not insane.[9] The rate of patients discharged benefitted by treatment based on first admissions was 44.8 per cent; based on all admissions, 35.6 per cent. At the end of that same year there were 4,060 patients on parole from the civil state hospitals, while the average number on parole during the year was 3,812. Undoubtedly some of these thousands of patients would have improved sufficiently to have been discharged or paroled during the year even had they not received psychiatric care, but a great many more would have remained in the hospitals. The additional hospitals needed to confine this latter group would cost the state many millions of dollars in addition to the annual cost of maintenance. It is evident then that, though the cost of treating the insane is very great, the cost of not treating their illness but merely confining them is also very great. Since the latter is cumulative, it may well be that it is greater than the former.

It is true, of course, that many patients are committed to hospitals for the insane who would not be sent to custodial asylums, at least at such an early period in their illness. Even this does not necessarily add greatly to the expense to the state. This is because many of these patients would require commitment later anyway, whereas there is a greater likelihood of their benefitting from treatment if it is administered in the earlier stages of their illness.

D. *The Taxpayer's Interest in the State Hospital Program*

However necessary and desirable it may be to provide hospital care for the insane the fact remains that the annual expenditure of twenty-five million dollars for this purpose is a heavy burden upon the taxpayers of the state. It is just as much the state's duty to be considerate of the taxpayers as it is to be considerate of the needs of the insane. It has been pointed out that for unavoidable reasons the state must maintain institutions for

[9] *Fortieth Annual Report of the Department of Mental Hygiene*, pp. 12–13.

the insane. Since this expenditure is unavoidable, what does the taxpayer's interest require?

It requires, first, that the necessary funds for maintaining the hospitals be raised in a fair and equitable manner; second, that the benefits of the system be limited to those for whose care the state is rightfully responsible; third, that the administration of the hospitals be as economical as possible; and fourth, that every feasible means be taken to reduce the numbers of patients who will require hospitalization.

E. *Scope of this Thesis*

It is with these questions of public finance connected with the state hospital system of New York that this thesis is concerned. The scope of the thesis is further restricted to those aspects of these questions which are essentially peculiar to the public care of the insane. The questions thus excluded all have to do with expenditures.

The first of these has to do with expenditures for personal services in the hospitals. In the fiscal year 1927–28 this item amounted to $8,247,936.82. It is, moreover, an item which is steadily growing as larger accommodations are provided and more patients cared for. Public finance has a direct interest in the efficiency of the methods governing this expenditure. First there is the question as to whether or not employees are chosen under a merit system so as to insure the employment of capable workers who will not waste the state's money. Then there is the question as to whether provision is made for promotions for merit and increasing salaries with length of service so as to discourage a high rate of turnover among employees and to prevent the waste which results from breaking in new employees. Thirdly, there is need for a pension system to offset the low salaries common in government positions and to further encourage long term employment. Fourthly, there is the very important matter of classifying positions and salaries so that employees doing work of equal value will receive equal pay. Each of these is a matter of concern to public finance as each is an important factor in determining whether or not the state will receive good value for the taxpayers' money. There is nothing about the

merit system of appointments as applied to the Department of Mental Hygiene, however, which is in any respect peculiar. The system has the same arguments in its favor, the same difficulties in the way of its application here as elsewhere. The same is true of classifying positions and services and of each of the other points mentioned above. Since each of these questions has been treated at length elsewhere there is no point in doing more here than to point out that in the public care of the insane each is of great importance both to secure efficiency and to save tax money.

The same may be said of the questions which arise in connection with expenditures for maintenance and operation of the hospitals other than for personal services. These expenditures amounted to $9,356,745.34 in 1927–28 and normally are about ten per cent greater than the expenditures for personal services. The principal questions arising in connection with these expenditures have to do with standardized specifications, centralized purchasing, seasonal purchasing of some commodities, auditing methods and taking advantage of discounts. It is a matter of interest to the taxpayers that these economical methods be used but there is nothing about their application to the purchase of supplies for the hospitals which is in any way unique.

The third big item of expense in connection with the state hospitals is the cost of new construction and permanent betterments. Each year there is an excess of admissions over deaths and discharges. The capacity of the hospitals should be added to by this amount each year if the function of the hospitals is to be fulfilled. Since it is to be expected that there will be such an annual increment of new patients added to the hospital population year after year, fairness to future taxpayers requires that the annual cost of new construction be met out of current funds, at least to the extent that this construction is merely to provide for the year's increment of new patients. Table IV shows how large the excess of resident patients has been each year for the last eight years. The average annual excess of resident patients during this period has been 1,054, and the total increase in the number of resident patients, 8,433.

TABLE IV

ANNUAL INCREASE OF RESIDENT PATIENTS, 1922–1929

YEAR	ANNUAL INCREASE	YEAR	ANNUAL INCREASE
1922	827	1926	1,056
1923	289	1927	1,486
1924	956	1928	1,649
1925	1,323	1929	847

Annual increases calculated on the basis of the resident population of the hospitals on June 20th of the years specified. Data taken from the annual reports of the Department of Mental Hygiene, and those of its predecessor, the State Hospital Commission.

If the hospitals are to fulfill their functions with maximum efficiency expenditures for new construction and permanent betterments cannot at present be confined to the amount needed to provide for the annual increase in the number of resident patients. This is due to the fact that the existing hospitals are overcrowded to the extent of 30.3 per cent of their certified capacity. As a matter of fact the certified capacity of the hospitals has never been equal to the number of patients accommodated, but the overcrowding has never been so serious as now.

In 1923 when the overcrowding was only 23.9 per cent, the State Charities Aid Association commented as follows upon the situation:

"This overcrowding retards the cure of patients, prolongs their stay in the hospital, and thereby increases the expense to the State for their maintenance, to say nothing of the discomfort of the helpless wards of the State.

"In spite of limited and insufficient facilities, and constant congestion, the State hospitals restore to mental health thousands of sufferers from mental disease. But it is a fact many other mental patients have failed to recover, because State hospitals have not possessed accommodations commensurate with the demands made upon them.

"Never since the State assumed responsibility for the mentally disabled, have accommodations been sufficient. With the exception of one or two years, each year has seen the demands upon State hospitals exceed the additional facilities provided. During the world war new construction practically ceased and the present critical situation has followed. In view of the past experience, it is evident no relief can be secured until current appropriations are supplemented with additional funds.

"The bond issue for State institutions affords the only means whereby the State can do its full duty in the matter."[10]

In pursuance of this suggestion a bond issue of $50,000,000 to increase the capacity of state institutions, chiefly those for the insane, was approved by the voters in November, 1924. One-fourth of this amount was to be available for appropriation each of the next four years. This money has been duly appropriated and is being utilized for hospital construction. It is not, however, giving the relief it was supposed to. In the first place, the purchase of appropriate lands and the construction of hospitals thereon takes considerable time. As a result the new quarters for patients provided each year have not been equal to the increase in the number of patients. Table V shows the figures as to the extent of overcrowding in recent years and shows to what extent the new quarters provided for patients offset the year's increase in the number of patients.

This brings out another point. The proceeds of this bond issue were intended to relieve existing overcrowding, not to provide for each year's quota of new patients.[11] No provision has been made from current funds for accommodations for more than a small fraction of the current increase of patients. This means that even when the new hospitals provided by the bond issue are completed the situation in regard to overcrowding will be as bad as before. Although it may have been justifiable to remedy the cumulative negligence of the past by a bond issue which would distribute the burden over a number of years, the state should, if it is to do justice to future taxpayers, at the same time provide increased hospital facilities for at least a thousand additional patients every year.

Other questions in connection with expenditures for new construction and permanent betterments which concern the taxpayers have to do with:

1. The selection of suitable sites for new hospitals. This

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[10] *Thirty-fifth Annual Report of the State Hospital Commission*, pp. 82–83.

[11] Part of the bond issue was to be used to remove fire hazards and for similar improvements to existing institutions.

question will be considered in more detail in connection with the employment of patients.

2. The type of construction best suited to hospital requirements.

3. The procedure for letting contracts, supervising construction, etc.

TABLE V

Overcrowding, Etc., in State Hospitals

Year	Increase of capacity during year	Increase of resident patients during year	Overcrowding at end of year	
			Number	P. C.
1922	240	827	7,229	23.7
1923	237	289	7,281	23.7
1924	116	956	8,121	26.3
1925	841	1,323	8,603	27.2
1926	839	1,056	8,820	27.1
1927	419	1,486	9,887	30.0
1928	1,794	1,649	9,742	28.1
1929	53	847	10,536	30.3

The last two of these questions are of the kind which are common to a number of departments. They will not, therefore, be treated further.

Having excluded so many questions from further discussion because they do not present essential features which are peculiar to the public care of the insane, what remains? First, there is the matter of raising funds for the hospitals in a fair and equitable manner. This involves reimbursement of the state by those patients who are financially able to pay for their care. Second, there is a group of questions in regard to the provision of care for aliens and non-residents. Third, there is the possibility of economical utilization of patients' activities to reduce maintenance costs. Finally, there are the financial aspects of measures designed to prevent insanity and to effect quicker improvement in the mental condition of the insane.

II

Reimbursement

A. *Reasons for Requiring Reimbursement*

Although New York State is now spending annually about twenty-five million dollars for purposes related to the care of the insane, part of this amount is returned to the state in the form of payments for the care of patients. The total amount of these payments, and the average amount per paying patient, has been increasing steadily in recent years until the fiscal year ending June 30, 1929. In that year the total amount collected was $26,306.38 less than the previous year. This decrease is directly attributable to the transfer to newly opened Federal Veterans' Hospitals of a number of ex-service patients for whose care the Veterans' Bureau had been paying the state two dollars a day. Table VI shows the amounts collected for the care of reimbursing patients in the years 1918 to 1929, inclusive.

TABLE VI

Collections from Reimbursing Patients, 1918–1929[1]

Year	Resident Patients	Reimbursing Patients		Amount Collected per Paying Patient	Total Collected
		Number	Per Cent of Total		
1918	35,142	3,484	9.9	$152.90	$532,706.35
1919	35,365	3,653	10.3	159.47	582,544.45
1920	35,718	4,302	12.0	176.49	759,257.47
1921	36,212	4,868	13.4	208.15	1,013,252.35
1922	37,398	4,915	13.1	263.85	1,296,383.55
1923	37,936	4,966	13.1	277.55	1,378,335.32
1924	38,382	5,139	13.4	245.98	1,264,069.11
1925	39,726	5,831	14.7	280.46	1,635,415.93
1926	40,866	6,071	14.9	284.63	1,727,989.93
1927	42,121	6,553	15.6	267.86	1,755,386.91
1928	44,472	6,430	14.5	289.62	1,862,244.98
1929	45,319	5,964	13.2	307.83	1,835,938.60

[1] Compiled from statistics in the *Fortieth Annual Report of the Department of Mental Hygiene*. 1929 data are from the *Forty-first Annual Report*.

Table VII shows how these amounts compare with the expenditures of the Department. The percentages in column I are found by dividing the total amount collected from reimbursing patients by the total spent on account of the insane; those in column II by dividing the total amount collected by the amount spent for maintenance and operation of the hospitals, excluding expenditures for new construction and permanent betterments. Neither of these shows to exactly what extent the cost of care is met by reimbursing patients. For any one year column I is not an accurate guide because expenditures for new construction fluctuate greatly from time to time, and also because the expenditures for new construction of any chosen year will be greater than the interest charge on the investment per patient. On the other hand, since column II makes no allowance for interest on the state's investment, the percentages there shown are consistently a little too high. Column II, however, shows the recent trend toward collecting a higher percentage of the cost of maintenance, while column I, in spite of its irregularities, is a closer index of the actual percentage of the cost of providing for the insane which reimbursing patients return to the state.

The fact that this much of the cost of the state hospital system is returned to the state by patients who pay for their treatment suggests the question: Why does the state collect this much and no more? Why are the patients not required to meet the entire expense of providing their care?

TABLE VII

PERCENTAGES OF EXPENDITURES ON ACCOUNT OF THE INSANE AND EXPENDITURES FOR MAINTENANCE AND OPERATION OF THE STATE HOSPITALS RETURNED TO THE STATE BY REIMBURSING PATIENTS[2]

YEAR	COLUMN I	COLUMN II	YEAR	COLUMN I	COLUMN II
1918		5.8	1924	7.1	8.8
1919	4.9	5.1	1925	8.4	10.7
1920	5.7	6.0	1926	7.9	10.7
1921	6.1	7.4	1927	6.9	10.4
1922	8.1	10.4	1928	7.5	10.6
1923	9.6	11.1			

[2] Computed from data in the annual reports of the Department of Mental Hygiene and of the State Hospital Commission.

The answer to this question is obvious. A large majority of the patients cared for in state hospitals for the insane have no property nor any relatives liable for their support who are able to pay for their care. As shown in Table VI, there has been only one year (that ending June 30, 1927) when the state has been able to collect anything from more than fifteen per cent of the resident patients. An inquiry directed to the officials of other states produced the information that the experience of New York is typical of the experience of other states.

There are good reasons why this is so. In the first place, no matter how much the therapeutic function of mental hospitals is stressed they must always retain their custodial function. Patients will be sent to them regardless of their ability to pay for treatment because of the fact that the patient must have special care either to protect himself and those with whom he is in contact or else to relieve his relatives and friends of the often distasteful necessity of caring for him at home. Persons of similarly limited means suffering from somatic diseases would often not seek the aid of charity and would not have it thrust upon them because their going untreated is not such a direct and noticeable menace to the community.

A second important reason why such a small percentage of the patients in mental hospitals can contribute toward their own support is the chronic nature of the psychoses of the large majority of resident patients. The average duration of hospital life of the patients who died in the New York state hospitals during the year ending June 30, 1928, was 6.1 years; of those dying the previous year, 6.6 years. This average period would be much longer were it not for the fact that a great number of those dying in the hospitals are senile patients who die within a few weeks of their admission. Thus, for instance, 19.5 per cent of those who died during the year ending June 30, 1928, had been in the hospitals less than one month. Of the patients with dementia praecox, who constitute more than 50 per cent of the resident patients and whose recovery rate is very low, the average duration of hospital life of those dying the same year was 16.8 years. It is obvious that only a very small percentage of these patients could continue to be self-supporting during such an extended period of incapacity.

If the state must give free treatment to eighty-five per cent of the patients in its mental hospitals, should it not also provide free treatment for the other fifteen per cent? Many persons believe that it should, and not always because the law makes them liable for a patient's support. To determine the justice of the New York practice of requiring patients who are financially able to pay for their care to reimburse the state, the statutes of all the states were consulted to see whether this practice is universal or not. This study showed that all but three of the states make some sort of provision for collecting the costs of maintaining insane persons from their estates or relatives, or from both, when their ability to pay has been established. In two of these three states, Virginia and West Virginia, there is provision for charging certain voluntary patients in the state hospitals but these are of negligible importance. In the third state, Oregon, reimbursement was formerly provided for but the law has now been changed so that all mental patients are cared for at public expense.

In Illinois, reimbursement is provided for in Chapter 23, section 23, Revised Statutes, 1925. However, in the case of Board of Administration of State of Illinois v. Miles, 278 Ill. 174, this section of the statutes was declared to be in violation of the state constitution. The court said in part:[3]

"The right of the State to require the patients in State hospitals for the insane to be supported out of their own estates is not questioned, but it is insisted that the method by which this is sought to be accomplished by the section in question is unconstitutional."

The court went on to show that the statute in question denied certain persons the equal protection of the laws and attempted to delegate legislative power to the Board of Administration. No change has been made in the Illinois statutes dealing with this subject although several years have elapsed since this decision was rendered.

After having consulted the statutes a questionnaire was sent

[3] 278 Ill. 174, 176–177.

to an official of each state asking whether it was the practice in his state to require persons of ability to reimburse the state for their care in state hospitals, and if not, why not. This was followed by the leading question: "Is it because the insane are considered so unfortunate as to be fit recipients of charity; because it is believed that the revenue derived would not warrant the expense of collection; because this source of revenue has been overlooked; or for what other reason?" This questionnaire elicited the information that in Georgia patients in the state hospital are not charged for their care although section 1605 of the Georgia Code, 1926, provides that those of ability shall be. The statement as to the practice in Georgia is as follows:

"The Board of Trustees have held to the idea that it was wisest not to charge and make the hospital entirely eleemosynary so that all could and would be treated the same."[4]

Presumably the Trustees have the power to do this under the provision of the Georgia Code (section 3102(1)) which states that they may specify the amount to be paid by patients who have estates of less than $3,000.00.

Since this letter seems to imply that a state cannot collect from mental patients unless it affords them special treatment, an investigation was made to determine the laws, and especially the practices of the other states. An official of each state was asked: "Are special privileges or treatment accorded patients who contribute toward the cost of their care?" Of the thirty-six replies which have been received to date, only two are in the affirmative. Delaware provides special food for all paying patients and private or semi-private rooms if they pay enough.[5] In Michigan all patients are treated alike but, "A private patient might, of course, pay for and receive some special treatment."[6] Examination of the laws of the other twelve states is not conclusive. Seven are silent on the subject. One provides that

[4] Unsigned endorsement on questionnaire referred by the State Treasurer to the Superintendent of the State Hospital.

[5] Reply to questionnaire referred to the Superintendent of State Hospital.

[6] Reply of Helen L. Cavanagh, Secretary to the State Treasurer, Michigan, February 13, 1930.

all shall receive equal treatment according to their respective needs. The other four fall in the class with Michigan.[7] Even so, the evidence is overwhelming that it is not generally felt that a patient who pays for his treatment in a state hospital must necessarily receive different treatment from those whose care is free. Delaware is the only state from which definite information is at hand where there is any real discrimination in favor of those patients who pay the regular rates for their care.

The reply from Virginia is as follows:

"Virginia does not charge insane patients in public institutions for the cost of their care. The question of collection does not enter into the matter; the State regards the insane as unfortunates who should be provided for by the State."[8]

The merits of this viewpoint will be discussed later.

No reply to this question has been received from West Virginia The laws of that state are so similar to those of Virginia in respect to this matter, however, that it seems to be a reasonable assumption that both states had the same reason for adopting the same system.

A somewhat different reason seems to have led the Oregon legislature to repeal the old Oregon statute providing for reimbursement. This reason is voiced by the Hon. Thomas B. Kay, state treasurer, as follows:[9]

"At one time the state did require some payment for support from relatives of patients but we found that those who were most able to pay refused to do so on the ground that they paid for such services in the way of property tax, and the state collected most of its income for this purpose from those who were the least able to pay, therefore the law was repealed."

If the Oregon officials charged with enforcing the old law permitted those best able to pay to escape payment on this ground, it was doubtless fairer to repeal the law. There was, however,

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[7] Alabama, Arkansas, Kentucky and Nebraska.

[8] Letter from the Hon. Frank Bane, Commissioner of Public Welfare, Virginia, February 12, 1930.

[9] Letter of February 11, 1930.

nothing in the law of Oregon to support the contention that the payment of property taxes entitled a person to free treatment in the state hospitals.

This same contention was made by respondent's attorney in the case of State Commission in Lunacy, Appellant, v. E. D. Eldridge, Respondent.[10] In declaring it to be without merit, Judge Hart presented an excellent statement of the grounds for requiring reimbursement of patients and their relatives who are found able to pay. He said in part:[11]

"But we are met by the argument that, since the state has taken the responsibility of caring for and maintaining those unfortunates, and for that purpose imposes upon all property owners a tax for the support of the institutions established to attain that object, it amounts to a species of double taxation to require individuals who have relatives in said hospitals to pay for or contribute to their support. This position proceeds, we are inclined to think, from a misconception of the real, paramount purpose intended primarily by the legislature to be achieved by the establishment of state institutions for the care and maintenance of the insane. Of course, one of the purposes is no doubt to protect the citizens against the violent acts of such insane people as may be dangerous, and who, if at large, would likely be a menace to the lives, persons and property of the citizens. But the principal purpose was and is to care for indigent insane, who in some cases may be successfully treated for the malady, or, if incurable, care for and maintain them as dependent persons, themselves without means or without relatives having means to properly care for them, being liable, if able, under the law so to do. In other words, the main object of the state in the maintenance of such institutions is much the same as that of counties in the maintenance of hospitals and poorhouses to care for and minister to the necessities of the indigent sick and others unable, through old age or other physical infirmities, to take care of themselves. If some one, having estate sufficient to defray the expense of his own care and support, or having no estate, but relatives legally liable for his care and maintenance, with ability to provide it, were to go to a county hospital or poorhouse for such care and maintenance, would it be a supportable proposition that, because he or his said relatives have borne their proportion of the general tax, such person could secure the benefit of such care and maintenance without paying something toward it? If such a proposition could be maintained, there would then be nothing to interfere with the filling

[10] 7 Cal. App. 298.
[11] *Ibid.*, pp. 304–307.

of the county hospitals and almshouses with persons well able to pay for their own care, who would thus, without cost to themselves, be maintained at public expense—at the expense of many other taxpayers having no interest in such institutions further than approving by supporting them as a proper and necessary mode adopted by the government for taking care of those unable to take care of themselves. We can see no distinction in principle in this regard between such county institutions and state hospitals for the insane, and the argument which has been advanced that in the latter case the inmates are confined in the hospitals without their consent by the state does not answer the proposition. The liability for their support rests, as we have seen, upon a legal as well as natural duty, and their forcible detention inures as much to their benefit and to that of relatives obliged to contribute toward their care and support as to the state. As is said in the case of Estate of Yturburru, 134 Cal. 467 (66 Pac. 729): 'An insane person is liable for the reasonable value of things furnished to him, necessary for his support. (Citing Civ. Code, sec. 38.). This was so at common law, when the necessaries were furnished by an individual, and we have never seen a case, and do not think any can be found, holding that this rule comes in conflict with any provision of the constitution of this state or of any other state in the Union. We see no reason why the same rule should not apply to a state hospital for the insane, which does and furnishes for the insane person only those things required by the law of the state.'

"We find nothing in any of the cases cited by respondent, with the possible exception of Baldwin v. County of Douglas, 37 Neb. 283 (55 N. W. 875), in conflict with the conclusions we have here reached. There is certain language used in the case mentioned, not necessary to a decision of the point involved, and which is therefore mere dictum, indicating that the court doubted the power of the legislature to authorize the collection by the trustees of a state hospital for the insane of a sum of money from the estate of the incompetent or from a relative liable for his support for his care and maintenance. But the facts of that case are altogether different from those of the case at bar. The Nebraska statutes require each county to pay for the care of its own insane at the state hospital, and each of the counties from which insane are sent to the hospital is authorized to and does levy a special tax for that purpose. This is in addition to the general tax for the support of the state government and its institutions. It was, therefore, properly held that the law requiring persons to pay for the support of their insane relatives in the hospital authorized, under such circumstances, double taxation and was therefore contrary to the state constitution."

A letter from Dr. R. E. Lee Steiner, Superintendent of the

Oregon State Hospital, implies that state hospitals should be free to the insane because they are so unfortunate, but that anyone who wants to pay for treatment can secure it at private sanitariums.[12] To determine whether private sanitariums are in fact accessible to those patients who are charged for their care in New York State Hospitals a letter was sent to each of the private sanitaria licensed by the Department of Mental Hygiene to care for insane patients asking for data as to their maximum and minimum rates. The replies received from twenty-five of these, with an aggregate capacity of more than ninety per cent of the certified capacity of the licensed institutions which are open to civilians, are tabulated in Table VIII. It is obvious that very few patients who are able to contribute toward the cost of their care in the state hospitals could long maintain themselves at these rates. In the licensed institutions which have minimum rates of less than fifty dollars per week the total certified capacity is less than one thousand patients. Judging from the scale of rates it is probable that about three-fourths of this number are charged more than that amount. Thus there are left only about two or three hundred beds available for patients at the maximum rate charged in the state hospitals. The rates charged by the private institutions are not excessive in view of the small numbers of patients which they accommodate, the luxuries which many of them supply, and the fact that nearly all of them are run for private profit,—but they do not furnish quarters for many of the patients who are able to be self-supporting in the state hospitals.

In summary, this study of the laws and practices of the other forty-seven states has produced the following arguments against the practice of collecting from the estates and relatives of insane patients in state hospitals,—all of which arguments have been refuted.

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[12] Letter of March 27, 1928. "Not one dollar is paid the state by the unfortunate insane or their relatives. Those who wish, however, can be cared for in private sanitariums at their own expense."

TABLE VIII

RATES CHARGED AT LICENSED INSTITUTIONS FOR THE CARE OF THE INSANE IN NEW YORK. (RATES PER WEEK).

NUMBER	MINIMUM RATE	MAXIMUM RATE	NUMBER	MINIMUM RATE	MAXIMUM RATE
1.....	$175	$875	14.....	$50	$150
2.....	175	up	15.....	50	75*
3.....	150	up	16.....	50	up
4.....	150	up	17.....	45	150
5.....	100	250	18.....	42	75
6.....	100	up	19.....	40	250
7.....	80	up	20.....	40	140*
8.....	75	200	21.....	40	125
9.....	75	up	22.....	35	85
10.....	75	up	23.....	35	up
11.....	75	75	24.....	35	up
12.....	50	200	25.....	—	50*
13.....	50	150			

* Extra charges for special nursing or other extra attention.

First, there is the question as to the constitutionality of the Illinois statute. In this case the court recognized the right of the state to require reimbursement, but objected to the phrasing of the particular Illinois statute in question.

Second, there is the argument that patients should not be charged since to do so would necessitate discriminating treatment which is considered undesirable.[13] It was shown, however, that discrimination is not the necessary result of charging patients because only one of the many states which charge patients does afford those patients any special treatment at the present time.

Third, there is the argument that the state should provide free treatment for the insane because they are so unfortunate as to merit it, regardless of their financial ability. This is refuted in the part of Judge Hart's opinion in the case of State Commission in Lunacy v. Eldridge quoted above, and, more particularly, in these words:

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[13] It should be noted here that New York and many other states formerly provided special treatment for private or paying patients but gave up the practice because it developed certain bad features, especially in that these patients were occupying unnecessarily large quarters when the capacity of the hospitals was taxed to the utmost. See Hurd, *op. cit.*

" . . ., as to the proposition of the alleged unequal burden imposed upon one class, thus, as contended, discriminating in favor of another upon whom the burden is not cast, the answer is, we think, that the so-called unequal burden is only one springing from a natural duty which, as to its performance, the legislature has recognized by positive enactment."[14]

So long as the state is unable or unwilling to make the care of all sick persons a public charge, it will not be unfair to mental patients to charge them for their care when they are able to pay for it. On the contrary, it would be unfair to the larger class of sufferers from somatic diseases to do otherwise.

Fourth, there is the argument that the payment of taxes entitles a person to free treatment in a state hospital. This argument is completely refuted in the case of State Commission in Lunacy v. Eldridge.[15]

Finally, there is the implication that persons who are able to pay for their treatment may go to private hospitals, but that the state hospitals should be free to all residents of the state who care to use them. It was then conclusively shown that the rates charged at such private institutions in New York are prohibitive to practically all of the patients who in the aggregate are able to contribute one and three-fourths million dollars a year toward the support of the New York State hospitals.

As a result of this study, then, we have found no valid argument against the state's requiring reimbursement, and the positive argument that failure to require it would be unfair to a large share of the people of the state.

There are two other measures of the desirability of requiring reimbursement which should be considered. First, is the cost of collection so great as to materially reduce the income of the state from this source? If it were found to be, the system would be condemned regardless of any theoretical merit it might have, for it would be wanton wastefulness to charge patients for their care if the proceeds are not to be devoted to that use. In New York the total appropriation of the legislature in 1929 for the personnel of the Reimbursement Bureau amounted to $35,150.

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[14] 7 Cal. App. 298, 304.
[15] *Supra*, pp. 25–26.

The appropriations for travelling and other expenses of the bureau are not entirely segregated, but appear to be between $25,000 and $30,000. Allowing the most liberal estimate, the expenses of collection do not constitute more than 3½ per cent of the amount collected. This can scarcely be considered too heavy a price to pay for the revenue derived.

The second measure of the desirability of requiring reimbursement is this,—Which is less desirable, the hardship imposed by the burden placed upon individuals made responsible for patients' care, or having the body of taxpayers shoulder the entire burden? Dr. Sandy, Director of the Pennsylvania Bureau of Mental Health, in an interview February 14, 1930, voiced a commonly held opinion when he said that he thought that in a great many cases collecting reimbursement either from a patient's estate or from relatives responsible for his care imposes unjustifiable hardship. Whether this is a necessary result of collecting reimbursement cannot be definitely determined. The statutes of nearly every state which requires reimbursement specify that collection is enforceable only in case of proven ability to pay. If this legislative mandate is carefully applied no undue hardship will result. It is the policy of the New York special agents in charge of assessing the amounts which shall be paid for the support of patients not to fix rates so high as to deprive the relatives and dependents of patients of funds needed for their support or welfare. If there is any criticism of their work, it is that sometimes persons of ability escape paying.

On all of these points, then, it is evident that the practice of requiring reimbursement is justifiable and desirable.

B. *Liability for Maintenance in New York State Hospitals; Who is Liable*

The Mental Hygiene Law,[16] sections 76 and 77, states who shall be liable for the support and care of patients in the state hospitals. Section 76 deals with "the poor and indigent", while section 77 deals with "other than the poor and indigent". "Poor person"

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[16] Chapter 426 of the *Laws of 1927*, constituting Chapter 27 of the *Consolidated Laws of New York*.

is defined as "a person who is unable to maintain himself and having no one legally liable and able to maintain him."[17] " 'Indigent person' means a person who has not sufficient property to support himself while insane, epileptic or mentally defective, and to support the members of his family lawfully dependent on him for support."[18]

Section 77 reads: "Liability for the care and support of the insane other than the poor and indigent.—The father, mother, husband, wife and children of an insane person, if of sufficient ability, and the committee or guardian of his person and estate, if his estate is sufficient for the purpose, shall cause him to be properly and suitably cared for and maintained."[19]

This section proceeds to provide for the commitment of such a person to a state hospital when it is found that

"such insane person is not properly or suitably cared for by such relative or committee, or that it is dangerous to the public to allow him to be cared for and maintained by such relative or committee."[20]

Section 76 reads: "Liability for care and support of poor and indigent insane.—All poor and indigent persons not in confinement under criminal proceedings, shall, without unnecessary delay, be transferred to a state hospital and there wholly supported by the state. The costs necessarily incurred in the transfer of patients to state hospitals shall be a charge upon the state. The commissioner shall, except as hereinafter provided, secure from the patient's estate and from relatives or friends who are liable or may be willing to assume the costs of support of inmates of state hospitals supported by the state, reimbursement at the rate fixed by the commissioner, in whole or in part, of the money thus expended . . ."[21]

Sections 914 to 920, inclusive, of the Code of Criminal Procedure also deal with this matter. Section 914 merely restates who may be compelled to support poor relatives.

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[17] *Mental Hygiene Law*, Art. 1, Sec. 2, par. 4.
[18] *Ibid.*, par. 5.
[19] Chapter 426, *Laws of 1927*, sec. 77.
[20] Chapter 426, *Laws of 1927*, sec. 77.
[21] *Ibid.*, sec. 76.

"The father, mother, husband, wife or children of a poor insane person legally committed to and confined in an institution supported in whole or in part by the state, shall be liable, if of sufficient ability, for the support and maintenance of such insane person from the time of his reception in such institution."[22]

The next five sections provide for the collection of the cost of care and maintenance when the person liable does not pay voluntarily.

"At the time appointed in the notice, the court or a judge thereof must proceed summarily to hear the allegations and proofs of the parties, and must order such of the relatives of the poor person mentioned in section nine hundred and fourteen, as were served with the notice and are of sufficient ability, to relieve and maintain him, specifying in the order the sum to be paid weekly for his support, and requiring it to be paid by the father, or if there be none, or if he be not of sufficient ability, then by the children, or if there be none, or if they be not of sufficient ability, then by the mother."[23]

The foregoing quotations show whom the laws of New York make liable for the care and maintenance of the insane, and the order in which this liability attaches to persons of different degrees of kinship.

The laws of the other states show a wide range of variation on this point. In every state where reimbursement is required at all, the patient's estate, if sufficient according to a variety of definitions, is liable. In nearly every state it is held that the patient's estate is primarily liable. In Pennsylvania, however, it has been decided that in the case of a married woman her husband, rather than her estate, is primarily liable.[24]

The laws of the several states are most varied as to which degrees of kinship shall be secondarily liable. Five states[25] limit liability to the estate of the patient. Ten other states,[26]

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[22] *New York Code of Criminal Procedure*, Sec. 914.
[23] *Ibid.*, sec. 916.
[24] Statement of Mr. Lloyd B. Shoap, Bureau Secretary, Pennsylvania Department of Justice, in an interview February 14, 1930.
[25] Arizona, Indiana, Mississippi, New Mexico, and Wyoming.
[26] California, Idaho, Kansas, Louisiana, Maryland, Minnesota, Ohio, Pennsylvania, Washington and Wisconsin.

the largest group whose laws are alike, extend liability to the same classes of relatives that are liable in New York. Not more than two of the other states agree upon any common rule.[27] In South Carolina, a husband is liable for the support of his insane wife and a father for the support of his insane minor children.[28] At the other extreme is Connecticut, where liability extends to husband, wife, father, mother, child, brother, sister, grandparents and grandchildren.[29]

Obviously the many variations of these provisions show that there is not even any consensus of opinion as to what relatives should be held liable. The weight of opinion is that there are certain relatives so close to the patient that they should be held responsible for his care. On the other hand, it would be illogical to extend this responsibility to too remote relatives, who have no direct personal interest in the patient. If the varying laws on this subject prove anything, it is that the New York statutes are reasonable, for nearly a fourth of the states hold the same classes of relatives responsible. Furthermore the New York practice is a mean between that of states which make only the patient's estate liable, and those like Connecticut which extend the liability to a long list of more distant relatives.

One other fact was disclosed by this study of the laws of all the states dealing with this matter. That is that, with a few exceptions, those persons whom the laws of the state make liable for the care and maintenance of insane persons in state institutions are the same as those persons who would be liable for the support of other relatives of the same degree who are poor but not insane. Nothing could be fairer than this. By this test the laws of New York are eminently fair.

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[27] Data in this paragraph secured by letters from, or personal interviews with responsible officials of thirty-six states, checked by reference to the statutes of each state.

[28] Letter of February 8, 1930, from Dr. C. F. Williams, Superintendent of the South Carolina State Hospital, Columbia, S. C.

[29] Section 1667 of the *General Statutes of Connecticut*, as amended by Chapter 101, *Laws of 1921*.

C. *The Basis of Assessing Charges; the Limit of Legal Liability*

The laws of New York do not furnish a definite rule as to how much the state may charge patients and the relatives liable for their care. The only reference to the maximum amount collectible occurs in section 76 of the Mental Hygiene Law.[30]

"The commissioner may fix the rate to be paid for the support of an inmate of a state hospital by the committee of such inmate or by relatives liable for such support or by those not liable for such support, but willing to assume the cost thereof; but such rate shall be sufficient to cover a proper proportion of the cost of maintenance and of necessary repairs and improvements."

The implication of this rule is that the commissioner may fix as high a rate as he sees fit. It does, however, set a minimum for those of ample capacity to pay, but even this minimum rate depends upon the interpretation of the words "proper proportion". Presumably it means the per capita cost of maintenance. This in turn could be held to include an item to cover interest and depreciation on the state's investment, or to exclude such charges. Whatever interpretation is placed on these words, it is evident that the maximum amount which will be charged is left to be determined pretty much by the commissioner's discretion. The maximum rate actually charged at present is fifty dollars a week.

The above-mentioned rate is, of course, only the maximum. Section 76[31] also says:

"The commissioner shall, . . ., secure . . . reimbursement at the rate fixed by the commissioner, in whole or in part, of the money thus expended, . . . The commissioner may, in his discretion, waive the whole or a portion of the claim of the state for the cost of the support of a patient against the estate of such patient, whenever the court by which a committee was appointed shall have directed such committee to apply any part of the patient's estate for the maintenance of his family."

The implication here is that in every case the amount of reimbursement required shall be reduced to conform to the individual's

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[30] Chapter 426, *Law of 1927*.
[31] Mental Hygiene Law, Chapter 426, *Laws of 1927*.

ability to pay, and that when a patient has dependents they shall have first claim to his estate, if it is necessary for their support. The first of these implications is definitely substantiated in section 916 of the Code of Criminal Procedure, quoted above;[32] the second may be reasonably derived from the wording of section 76.

On the basis of the amounts paid the state for their care the patients in the New York state hospitals may be grouped in three classes. First, there are those for whose care the state receives nothing; second, those who reimburse the state to some extent but not more than the actual cost of their care; and third, those who reimburse the state in amounts ranging from the actual cost up to fifty dollars per week, the maximum rate now charged.

The existence of this third class raises a question as to whether the state should charge patients more than the per capita cost of their care. If the state hospitals were on a purely business basis, they might justifiably charge what the traffic would bear. It is evident, though, that they are not on such a business basis. Primarily, they are to give relief to those insane persons who are not able to pay for their own care. But does this necessarily prevent the state from charging those who are able to pay rates comparable to those which they would be charged elsewhere?

There seems to be no good reason why state hospitals should not make a reasonable profit from the care of patients who are of sufficient means so that such payments will not entail undue hardships. The Mental Hygiene Law[33] (section 77) makes the estate and relatives of an insane person primarily responsible for his proper and suitable care and maintenance, when the insane person is neither poor nor indigent. When this responsibility is accepted in a proper manner none of the expense of the patient's care is borne by the state. The entire cost is a charge against one or more individuals.

This care may be afforded the patient either at home or in one of the privately operated institutions licensed by the state to care for such patients. As shown in Table VIII[34] these

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[32] *Ibid.*, p. 40.
[33] Chapter 426, *Laws of 1927.*
[34] *Supra*, p. 28.

institutions charge from $35.00 to $875.00 per week.[35] The cost of caring for an insane person at home varies according to the individual patient's needs, but would certainly approximate fifty dollars a week whenever special medical care or nursing is required.

The Mental Hygiene Law further provides that

> "when a judge finds and certifies in the order that such insane person is not properly or suitably cared for by such relative or committee, or that it is dangerous to the public to allow him to be cared for and maintained by such relative or committee,"[36]

he shall be committed to a state hospital. In such cases the primary liability of the patient's estate and relatives for his support remains. Since the state provides care only when they have neglected their duty, it is logical that the state hospital be allowed to charge rates comparable to the expense of care elsewhere.

The practices of the other states in respect to this point, while proving nothing as to the rightness or wrongness of this practice, are of interest.

No other state has such a high maximum rate as that of New York. Nevertheless, of the thirty-three states from which definite information on this point is at hand eleven have maximum rates higher than the per capita cost.[37] In most of the states the maximum rate is fixed periodically so as to equal roughly the per capita cost of the preceding period. In several states the maximum rate is fixed by statute. The lowest rate so fixed is

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[35] In three of these institutions, provision is made for caring for a very limited number of charity cases.

[36] Chapter 426, *Laws of 1927*, sec. 77.

[37] Arizona, maximum rate $1.00 per day, per capita cost $.80; Connecticut, maximum $15.00 per week, 50 per cent more than per capita cost; Delaware, $25.00 per month, per capita cost $10.00; Florida, maximum $100.00 quarterly, per capita cost $28.00 per month; Maryland, $2.00 per day, per capita cost $240.00 to $320.00 per year; New Hampshire, $7.00 per week, per capita cost a little less; Pennsylvania, certain veterans supported by the Veterans' Bureau at more than cost; South Carolina, maximum $1.00 per day, per capita cost $.90; Texas, maximum $5.00 per week, per capita cost less; Vermont, maximum $8.00 per week, per capita cost $1.75 less; Wyoming, maximum $25.00 per month, per capita cost less. Information from correspondence.

in Minnesota, where the statutory rate of ten dollars per month is equal to about two fifths of the per capita cost of maintenance.[38] Arkansas, California, Indiana, Kansas, Maryland, Massachusetts, Mississippi, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Washington and Wisconsin also have maximum rates fixed by statute from four dollars a week in Arkansas and Mississippi to ten dollars a week in Massachusetts. In most of these states the statutory rate was fixed several years ago when the expenses of maintaining state hospitals were not so high as they are now. At present such rates are evidence of the desirability of greater flexibility in the wording of laws providing for reimbursement.

In respect to the amount to be collected from persons unable to pay the maximum rate the practice of several states differs from that of New York in that such persons are not required to pay anything.[39] In New York, where the maximum rate is so high that few persons can pay it, such a rule would materially reduce the receipts from this source. Furthermore, there appears to be no logical reason for such a rule.

The general rule in every state which requires reimbursment is that actual ability to pay shall determine whether or not payment is to be made. Except for the group of states last mentioned, the rule of ability to pay is carried a step farther so that persons who are unable to pay the whole charge are still liable for so much of it as they are able to pay.

There are many variations from this rule. In some states a person's entire estate and income are considered in determining whether or not he shall be required to pay anything. In others the laws specify that the homestead shall be exempt. In still others there is a specified minimum amount of property which is not to be taken for reimbursement. In Vermont the exempt property is only $300.00.[40] In Wyoming the exemption is one thousand dollars for single persons and three thousand dollars for married persons.[41] In California payment is not exacted

[38] Letter of February, 1930, from E. W. Allen, Director, Bureau of Support, Parole and Deportation of Insane.
[39] Arizona, Mississippi, Montana, Nevada, Texas and Wyoming.
[40] *General Laws of Vermont*, sec. 4289.
[41] *Session Laws of Wyoming, 1929*, Chapter 155, sec. 10.

when there is likelihood of the patient recovering and when payment would reduce the estate so as to make him, if discharged, a burden upon the community.[42] The New York rule has already been quoted on page 34, above.

In summary, this can be said about the New York system:

1. The commissioner has wide powers of discretion in fixing the rate to be paid. The maximum rate now collected is fifty dollars per week.

2. This maximum rate is more than the per capita cost but since it is charged only those who are able to pay it, and whose care the state undertakes only in default of other satisfactory provision therefor, and since this rate is moderate in comparison with the cost of maintaining such a patient elsewhere, it appears to be a reasonable charge.

3. Persons not able to pay the maximum rate are charged less according to their respective abilities to pay. Here again, in determining how much each person shall pay, the commissioner has wide discretionary power.

In conclusion, it may be said that this system has the dual advantage of securing all the reimbursement to which the state is entitled, and of being flexible so that the rates charged may be changed from time to time as hospital costs rise or fall.

The question as to whether or not the system leaves too much to the discretion of administrative officers will be discussed in the next section of this chapter.

D. *The Determination of Individual Ability to Reimburse the State; Administrative Organization and Procedure.*

There are two things to consider in respect to the way in which an individual's ability to reimburse the state is determined. These are the administrative organization and its methods of procedure.

Section 24 of the Mental Hygiene Law provides for the necessary organization. It reads:

"Agents for securing reimbursement to the state of the cost of maintenance of inmates.—The commissioner may appoint agents, whose duty it shall be

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[42] *California Political Code*, sec. 2181.

to secure from relatives and friends who are liable therefor, or who may be willing to assume the cost of support of any patient or inmate in a state institution in the department, who is being supported by the state, reimbursement, in whole or in part, of the money so expended. The commissioner may designate an agent to be in charge of the agents in the metropolitan district and may designate an agent to be in charge of agents outside the metropolitan district. The compensation of each agent shall be fixed by the commissioner within the amount appropriated therefor. Each agent shall receive his necessary traveling and other incidental expenses incurred by him, to be audited by the comptroller."

Acting under the authority of this section of the Mental Hygiene Law the commissioner has organized the Reimbursement Bureau, with the following personnel:—1 director in the Albany office of the department; 1 special agent in charge of the metropolitan district; 4 special agents in the metropolitan district, and five special agents, one assigned to each of the five upstate districts; a stenographer in each office. In the upstate districts the agents report directly to the director of the bureau, whereas in the metropolitan district they report to the agent in charge, who in turn reports to the director. All of the work of the bureau is subject to the supervision and direction of the commissioner of mental hygiene.

As has just been indicated, the state has been divided into six districts for the purpose of investigating the financial status of patients and their relatives. Half of the agents are assigned to the metropolitan district which includes the counties of Bronx, Kings, Nassau, New York, Queens, Richmond and Suffolk,—in other words, New York and Long Island.[43] In the year ending June 30, 1928, 5,295 of the 8,614 first admissions to the state hospitals were residents of this district,[44] but because of its compactness an agent in this district is able to settle more cases per day than in the upstate districts where traveling over longer distances is necessary. For the same reason the areas of the different upstate districts vary considerably. Thus an agent who has a large district to cover has less thickly populated counties therein and consequently fewer patients' cases to investigate.

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[43] *Handbook of the Department of Mental Hygiene.*
[44] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 268.

According to the law the first step in the determination of the patient's ability to pay is taken at the time of his commitment. Section 72, paragraph 4, of the Mental Hygiene Law provides:

". . . If the commitment be made to a state hospital, the order shall be accompanied by a written statement of the judge as to the financial condition of the insane person and of the persons legally liable for his maintenance as far as can be ascertained."

As a rule, however, the information thus secured is of little value except as it affords a clue to the persons liable for the patient's care. In the cases of voluntary patients and those admitted to the hospital on a physician's certificate even this information is lacking.[45]

The next step is provided for in General Order No. 9, an order from the commissioner of mental hygiene to the superintendents of all state institutions in the department. It reads thus:

General Order No. 9. ALL STATE INSTITUTIONS

Information to be furnished reimbursement bureau.

All state hospitals, schools for mental defectives and Craig Colony, shall furnish the bureau information as follows:

1. List of patients admitted each month, giving their names and addresses, dates of admission, names and addresses of correspondents, and such information regarding the finances of the patients and relatives as they may obtain (Form 45-Adm.).[46]

2. Notice when legal papers have been served on the patients, giving the nature of the proceedings and when possible, furnishing copies of the legal papers.

3. Lists, at least every two months, containing the names and addresses of all patients whose accounts are delinquent, as well as the names and addresses of their correspondents and the amount due.

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[45] For the various kinds of admissions to the state hospitals see the *Mental Hygiene Law*, sec. 72. Mr. R. J. Corcoran, special agent in charge of the metropolitan district, is authority for the statement that the information furnished by the courts is generally of little value.

[46] Mr. Corcoran informed me that it has been found necessary to furnish this information to his office weekly because patient's relatives change their addresses so frequently in that district.

4. Notice when attorneys request that petitions be made for the appointments of committees other than when the request is made by the Attorney-General.

5. Such other information as they may obtain relating to the financial condition of the patients and their relatives.

6. In case of ex-service men information should be furnished as to the names of regiment and company, place and date of discharge from the army, and status with respect to Federal insurance and compensation.

The procedure in the metropolitan district may be used as an example of what happens after this information is supplied to the special agent. According to the latest practice this office receives each week a list of the newly admitted patients who are residents of that district. A form letter is sent immediately to the patient's correspondent requesting him to call at the office of the Department in the Flatiron Building during office hours the ensuing week in regard to the patient named.

When this appointment is kept the special agent in charge questions the correspondent as to the property or income, if any, which the patient has or receives. A record is made of the information thus secured. If it is found that the patient has securities or other property its exact nature is determined. In case he is found to have money in the bank, the amount in the account is always verified by the bank. Authority to secure this information from the banks is given in Chapter 71, Laws of 1924, the pertinent part of which reads as follows:

"Section 3.—Information to be given to poor authorities and state hospital commission by banks, savings banks and trust companies. If requested by an authorized representative of the state hospital commission,[47] or of the department of charities or similar department of any city, or by the authorities charged with the duty of administering laws relating to the poor in any town or county, the officials of a bank, savings bank or trust company shall furnish to such representative of the state hospital commission or to such city, county or town authorities information relating to facts of which such officials of the bank, savings bank or trust company shall have cognizance as

[47] The Department of Mental Hygiene, created by Chapter 584 of the *Laws of 1926*, took over the functions and powers of the State Hospital Commission.

to whether or not an inmate of a state hospital, named by such representative of the state hospital commission, or an applicant for relief, named in such request made by city, county or town authorities, or the husband or wife of such inmate or applicant, is not a poor person, and as to whether or not such inmate or applicant, his wife or her husband, has funds, securities or other personal property on deposit or in the custody of such bank, savings bank or trust company."

During this same interview with the patient's correspondent the special agent in charge determines whether the patient has any dependents and the extent of their dependency. In the great majority of cases, when the patient's estate is of negligible value, he also determines whether the patient has any relatives liable for his support, and, if so, the value of any property they may own and the amount of their incomes. He also inquires as to whether or not the relatives have other dependents whom they must support in whole or in part. Inquiries as to whether or not the relatives own their own homes, the rent they pay, the nature of the work they are engaged in, etc., supply an empirical basis for checking the accuracy of the correspondent's statements as to his income, obligations, etc.

In most cases, when the patient's correspondent has been interviewed, the agent in charge is satisfied from the information furnished that the patient has a negligible amount of property and that there are either no persons liable for the cost of his support, or else that such relatives as are liable have insufficient income to more than provide for themselves and their other dependents without imposing undue hardships. In such cases he recommends that no charges be made.

In most of the remaining cases he has determined either that the patient has sufficient property to warrant making a charge against it, or else that, the patient having negligible property, there are relatives liable, able and willing to pay some agreed upon amount for the patient's care. In such cases he recommends that bills for the specified amount be sent the proper person.

There remain a few cases where the information secured is either incomplete or unsatisfactory. As already noted,[48] banks

[48] *Supra*, p. 41.

must, when requested, provide information as to patient's property of which they are cognizant. Thus the determination of the value of a patient's own estate is not particularly difficult. It frequently happens, however, that the special agent in charge is not satisfied with the answers he receives as to the income and property of the patient's relatives. When this happens the case is assigned to one of the special agents attached to the office for further investigation.

The special agents who do outside work in the metropolitan district also make the original investigation of two types of cases, namely, those where the patient's correspondent fails to comply with the request for an interview within two weeks and those cases where the names or addresses of the patient's relatives are unknown.

The procedure in these outside cases is essentially the same. The principal difficulty met with in New York City is to locate the patient's relatives, due to frequent changes of address. The records of gas companies, electric light companies, etc., are of some help here but it is frequently necessary to wait until visitors go to see the patient to determine who the relatives are and where they live. One of the special agents in the New York district visits each of the hospitals in that district monthly and, among other things, secures this information. If no information is secured within a few months and there is no indication that any will be secured the case is closed, unless information is unexpectedly furnished in the future.

In checking up on the ability of patients' relatives to pay, the outside agents normally visit the person's community and question acquaintances, business associates, and such persons as postmasters and storekeepers in small communities. Of course, if the person in question has not already been interviewed and found evasive or suspicious he is also seen and an attempt is made to reach an agreement with him as to how much he shall pay.

When the investigating agent finds that a patient has sufficient estate to make the collection of reimbursement worth while steps are taken through the attorney-general's office to have a

committee of the patient's estate appointed, except in those cases where such a committee has already been appointed. This procedure is not customarily followed unless the patient is found to have an estate in the neighborhood of five hundred dollars or more because the incidental costs and fees otherwise eat up most of the estate without the state or the patient receiving any benefit therefrom. The committee of the patient's estate having been appointed, bills for the patient's care may be collected from the estate at the rate fixed by the commissioner, according to the recommendation of the special agent.

On the other hand, when the special agent has determined that the patient does not have sufficient estate to pay for his own care but that one or more of his relatives are able to do so, he attempts whenever possible to secure their voluntary agreement to reimburse the state at whatever rate the agent considers justifiable in view of the facts. The basic rate which is sought in most cases is fourteen dollars a week. When the person liable is unwilling to pay, it is usually sufficient to point out that he is liable under the law, but before doing so the agents prefer to appeal to personal pride not to have the responsible person's close relative cared for as a pauper. It has been the experience of the New York agents that a policy of convincing relatives of their interest in paying is more profitable to the state than insisting upon payment as a legal obligation. This is because the persons who are required to pay against their wishes are frequently delinquent and put the department to added expense and considerable trouble to enforce payment, in case they do not succeed in avoiding payment entirely. On the other hand, a person who is convinced that he should pay for his relative's care tends to do so even sometimes when doing so imposes a hardship upon himself.

The Mental Hygiene Law,[49] in addition to stating that the special agents shall seek reimbursement from the patients' estates and from their relatives liable for their support, provides that they may also collect from friends and relatives who are not liable but may be willing to pay part or all of the cost of a

[49] Chapter 426, *Laws of 1927*.

patient's care.[50] This is a source of considerable revenue for the state. Mr. Corcoran, the special agent in charge of the metropolitan district, says that in many cases brothers and sisters or friends of patients not legally liable for their care voluntarily pay for their care. In other cases relatives who are legally liable but whom the special agent does not consider to be of sufficient ability insist upon paying something toward the cost of their relatives' care because they do not like the idea of their being supported by the state as paupers. In this latter case delinquent payments often result. Since these require taking considerable time of several state employees to reinvestigate, it is questionable as to whether the practice is desirable.

At the end of each week the director of the reimbursement bureau is sent a full report of the facts found in the cases investigated during the week, together with the special agent's recommendation as to the disposition of the case. Ordinarily the agent's recommendation is accepted although the commissioner has power to make changes as he sees fit. The rate having been approved by the commissioner the steward of each hospital is instructed as to the amounts which he shall bill each person. The amounts received in payment are later paid over to the State Treasurer.[51]

The following points stand out as the important features of the New York system of determining how much shall be paid for a patient's care:

1. The determination of ability to pay is centralized in the hands of a small group of special agents who devote their whole time to this work.

2. The state has been districted so as to facilitate and equalize the work of the special agents.

3. The determination by the committing judge as to the value of the patient's estate and the ability of his relatives is of little actual value.

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[50] Sections 24 and 76.

[51] The above description of the organization and procedure of the reimbursement bureau, unless otherwise indicated, is based upon information furnished by Mr. J. F. O'Brien, director of the bureau, and Mr. R. J. Corcoran, special agent in charge of the metropolitan district.

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4. The ability of a person to pay for a patient's support i ordinarily determined in an interview between a special agent and the patient's correspondent, checked by further investigation only when the need thereof is indicated.

5. Having determined how much should be paid, the agents try to get the liable persons to pay voluntarily, instead of stressing the legal liability.

6. Large amounts are collected from persons not legally liable but willing to pay for the care of a patient.

In an effort to determine whether this system could be improved upon, inquiries were directed to officials of the other states to see what their practices might be. The replies, supplemented by study of the statutes of each state, show that in most of the states the committing judge is supposed to determine the amount to be paid for a patient's support. They also indicated that this method is no more satisfactory in those states where it is the sole means of determining how much a person shall pay than it is in New York where the judges only furnish information for the special agents to act upon.[52] On the other hand, those states which have a system comparable to that of New York get approximately the same results that New York does.[53]

There are also several other types of procedure in use in one or more states.[54] These appear to get good results according to whether or not responsibility for conducting the investigation is placed in the hands of a few special agents who devote their whole time to this work or whether the investigating agency is decentralized and non-specialized. The best results were

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[52] Letters from officials of seven of these states report collections from between 1½ per cent and 10 per cent of the patient population.

[53] Letters from officials of six of these states report estimated collections from between fifteen and twenty-five per cent of the patient population.

[54] Chief of these types are: Investigation by officials of the county of patient's residence, the county being charged by the state for the care of some or all of the patients from that county. (Examples: Iowa, Maryland and South Dakota) by each state hospital. (Examples: Louisiana, Indiana and North Carolina). In Michigan there is a collection department in connection with the Attorney-General's office. In Pennsylvania investigations are conducted by the Department of Revenue acting in conjunction with the Department of Justice. The counties are also charged part of the cost of support and may seek reimbursement separately.

found to be secured in those states whose systems were essentially the same as that of New York.

Provision for the payment of the cost of patient's care by persons not liable therefor was found to exist in the statutes of several of the states but in no case was information secured indicating that this source of revenue is developed to the same extent as in New York. It would seem that a little attention to the possibility of securing payments of this kind might be profitable to many states.

The principal remaining questions as to the merits of the New York system are:

1. Is a more intensive investigation of ability to pay desirable?
2. Is the department too lenient in fixing the amounts to be paid?
3. Is the practice of trying to get persons to pay willingly for the care of their relatives worth while?

As to the first of these questions there are only two things to be considered. Would such additional investigation disclose additional sources of revenue, and what would it cost?

There is little doubt but that some persons' ability to pay is not completely disclosed by the cursory questioning to which they are now subjected. On the other hand, the present methods probably disclose the principal factors which affect ability to pay in most cases. As to the expense, there can be no doubt but that a more intensive investigation would require a much larger staff and greatly increased expense accounts for travelling and incidental expenses. On the whole, it is very doubtful whether such a system would bring in enough additional revenue to offset the added expense.

As to the question of leniency the only evidence at hand is from the records of the department. The following records of two successive cases selected at random from the files of the special agent in charge of the metropolitan district are typical of a large number of cases examined.

No. 83815. Patient aged 26; single; chauffeur, no means; correspondent a painter, earns $28 per week; one daughter, earns $15 per week; will pay at rate of $10 per month. Bills at

this rate recommended to ....., father, at..... beginning March 1, 1930.

No. 83816. Patient aged 23; single; policeman; no means. Father, conductor at $31 per week; has 6 dependent children, rent $60; patient has aided in support of home; desire to pay maintenance at the rate of $7 per week. Bills at this rate recommended to ....., mother, at .....

In case No. 83815 the daughter is neither legally liable for the patient's support nor is she wholly dependent upon her father for support. That being the case, the only question is as to how much the father should be required to pay from his twenty-eight-dollar-a-week income. While it might be possible to collect more than ten dollars a month from him, doing so would seriously reduce the margin of comfort in his life. Furthermore, since he had no property to fall back upon in case of unemployment, a higher charge would be likely to impoverish the father as well as the patient.

In case No. 83816 the rate of $7.00 per week seems unduly high in view of the small income of the father and the large number of persons dependent upon him. In this case the agent would probably have not charged anything if it had not been volunteered. Where reimbursement imposes such a burden upon the patient's relatives as in this case delinquency in meeting payments is to be expected.

These two cases, which are typical of a hundred in the same folder, do not indicate undue leniency in fixing the amounts to be charged. This leaves only the question as to the desirability of relying upon the willingness of persons to pay for their relatives' care rather than stressing the legal nature of the responsibility. This feature of the New York practice needs no recommendation other than the fact that it tends to minimize the number of persons who will attempt to evade their responsibility.

E. *Enforcement of Claims for Reimbursement*

In a large proportion of the cases where someone is billed for the support of a patient payment is made fairly promptly

without further action on the part of the state. There is almost no trouble when the charge is made against the patient's estate, so long as the estate is sufficient. There are more cases delinquent when the charge is against one or more of the patient's relatives.

General Order No. 9[55] provides that each hospital shall send the reimbursement bureau a list of the names and addresses of delinquents at least every two months. This information is now furnished to the metropolitan district every two weeks.[56] The case is then assigned to one of the special agents for reinvestigation. Here again one of the biggest difficulties to overcome is in locating the person who is supposed to pay, as many of them move without leaving any address.

The reinvestigation of these cases is conducted in the same manner as the original investigation, except that they are all made in the field. Usually it is found that the payments have stopped because the person billed is no longer of sufficient ability to continue paying. In these cases the charge is modified or discontinued entirely.

It is frequently found, however, that the failure to pay is due not to inability but to unwillingness. In many of these cases the threat of legal action is sufficient to bring about the renewal of payments. Of course, when payments are being made by a person not legally liable for the patient's support they may be discontinued at any time.

If the special agents are not able to get the persons liable for a patient's support to pay voluntarily or under threat of legal action, there is in reality little that they can do in most cases. Sections 914 to 920 of the Code of Criminal Procedure provide that in such cases the treasurer of the state hospital may apply to the courts for an order directing the person who is liable to pay. In actuality this procedure is of very little use except when the liable person has considerable property or income.

According to this procedure the court must, after five days' notice to the persons liable, determine their ability to pay, and issue orders to them in accordance with his findings. In certain

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[55] See above, pp. 40-41.

[56] This material on the enforcement of claims for reimbursement is based on notes of interviews with Messrs. O'Brien and Corcoran.

clear-cut cases it is possible to get the orders issued. However, when the person whose ability is being ascertained has little property and small earning power it is very easy to evade payment.

Even when the order has been issued payment is by no means assured. If the patient's relatives choose to ignore the order it is necessary to bring suit to secure payment. It has been the experience of the department that so little is secured by this procedure that it is resorted to only after all other attempts to secure payment have failed, and when it is believed that enough will be forthcoming to pay for all of the time which is spent in the process.

F. *Redetermination of Ability to Reimburse*

At present the original determination by a special agent as to the ability of a patient and his relatives to reimburse the state for the patient's care is the only investigation of these persons' ability to pay unless payments are in arrears, the person applies for a reinvestigation because of his lessened income, or the reimbursement bureau is led to believe that the persons involved are able to pay more than they are being charged. Increased ability to reimburse is brought to the bureau's attention chiefly in reports from the hospitals of information which has come to their attention, in anonymous letters, and as a result of deferred investigations by a special agent when the first investigation indicated that a person might be expected to acquire additional property or have a larger income in the future.[57]

The cases where a person's ability to pay has dwindled since the original investigation can be expected to come to the attention of the bureau before they cause much hardship. On the other hand the bureau learns of enough cases where the patient's relatives have increased their incomes so that they can be charged higher rates to bring considerable additional revenue to the hospitals. This fact suggests the possibility that it might pay the state to have a periodic investigation to determine what persons liable for a patient's care have increased capacity to pay therefor.

[57] Information furnished by Messrs. O'Brien and Corcoran.

The governing factor here would be the relation between the cost of the investigation and the revenue derived as a result. The following calculations indicate that the cost of a general reinvestigation would be excessive.

There were 44,472 patients in the state hospitals on June 30, 1928. 10,853 patients had been admitted and their ability to reimburse the state determined during the previous year. But of these 10,853 patients it is likely that not more than about 5,000 remained in the hospital at the end of the year.[58] There are about 5,000 cases reinvestigated each year.[59] There remain, then, in the neighborhood of 35,000 patients whose ability to reimburse the state was not determined during the current year. Since the present staff investigates only between fifteen and sixteen thousand cases per year, a complete check-up on the ability of all of the patients and their responsible relatives would require about triple the present staff of special agents. Since by the present system the bulk of the persons able to pay are undoubtedly reached, there can be no question but that such a general reinvestigation would be a needless extravagance.[60]

Nevertheless, even though such a general reinvestigation would be extravagant, it seems that a more limited system of periodic reinvestigation would pay. Of the approximately 35,000 patients whose financial status is not determined within the current year a large number are known to have neither personal estates nor relatives. Another class have estates but no relatives. The first of these classes can be ignored once these facts are known. The second class can also be ignored so far as ability to pay is concerned until the committee of a patient's estate shows that the estate is no longer able to meet the charges. Of course there are rare cases where a patient's estate appreciates

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[58] According to the *Fortieth Annual Report of the Department of Mental Hygiene*, 1901 patients who had been in the hospitals less than a year died during the year ending June 30, 1928; 4,458 patients were discharged, and 4,060 patients were on parole. By a conservative estimate, 1,500 of those who died, 3,500 of those discharged, and 1,000 of those on parole were admitted during the same year. Thus only about 5,000 of those admitted during the year remained in the hospitals at the end of the year.

[59] Mr. Corcoran's estimate.

[60] Mr. O'Brien, director of the bureau, and Mr. Corcoran, special agent in charge of the metropolitan district, emphatically agree with this conclusion.

during his incapacity but these cases are so rare as to be negligible.

The possibility of securing more revenue comes almost entirely from those patients who have relatives liable for their support. Even many of these cases may be ignored. Where the original investigation has shown that there is no prospect of any of the liable relatives acquiring more property the case may be closed. But it seems that there would remain a sizeable group whose circumstances would warrant one or more reinvestigations at a later date. This plan is now followed in the more obvious cases, but it is believed that the employment of one or two more agents in this work would be worth while.

There is one other change that might be made in the New York system to good advantage. That is to authorize the collection from a patient or his relatives liable for his care of the full cost of his care to date when it is discovered that either the estate or the relatives have newly acquired ability to pay for the patient's care. This is not provided for in the New York laws at present but is a source of considerable revenue to a number of other states.[61]

G. *Summary*

The following points stand out as the chief principles for the collection of reimbursement for the care of the insane in the public hospitals of New York:

1. Fairness to the taxpayers of the state demands that in sane patients and those of their relatives who are liable for their support be required to reimburse the state for its expenditures on their behalf whenever they are of sufficient ability to do so.

2. After making due provision for other dependents, liability for the patient's care should be enforced, first, against the patient's estate, and, if that is not sufficient, against those relatives who are made liable by the laws of the state for the support of poor relatives. This liability should not extend to too distant relatives, nor should it be confined to a too restricted category.

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[61] E. g., Connecticut and Ohio.

3. The ability of the person liable, after due consideration for the needs of the individual and of any other dependents, should be the chief measure of the amount of reimbursement to be required. Since the state hospitals are provided to provide for those who cannot afford care elsewhere, those who can afford the care given by privately owned institutions may justly be charged rates comparable to the rates charged by those institutions.

4. To secure the maximum part of the revenue due the state from this source it is desirable to have the investigation of the ability of persons to pay placed in the hands of a few agents who devote their whole time to this work.

5. Tactful appeals to the pride of the patient's relatives to keep their relatives from being classed as paupers is a more effective method of securing reimbursement than insisting upon it as a legal obligation.

6. The same sort of appeal to persons not liable for a patient's support is a profitable source of income which should not be overlooked.

7. Reexamination of ability to reimburse is called for when payments are in arrears, when relief from payments is sought, and when there is any reason to believe that a patient or his relatives are liable for larger payments than they are making.

In general, all of these principles are now applied in New York,—more so than in most other states. The New York system could be improved by making a more systematic reinvestigation of all persons whose ability to pay may have increased since the original investigation, and by providing that in cases where a person's capacity to pay is found to have increased since the case was first investigated reimbursement may be collected for the period which had already elapsed. As it is now, the total and per capita amounts now collected in New York are greater than in any other state concerning which data are at hand.

III

Aliens, Non-Residents, and the Foreign-Born

A. *Persons for Whose Care the State is not Responsible*

Who, in fairness to the taxpayers, is entitled to care in the New York state hospitals? In so far as the hospitals' therapeutic function is concerned they have been established by the state to benefit members of the state through treatment. In so far as their custodial function is concerned they are for the purpose of protecting the members of the state from potentially dangerous persons. In either case the hospital is intended to promote the welfare of the citizens of the state.

It is not the function of the government of New York state to provide treatment for the citizens of other states in its state hospitals. It might be proper for the state to do so if it were to be reimbursed to the full extent of its expenditures, but it is not so reimbursed. It has already been shown that few of the patients in the state hospitals are able to contribute anything toward the expense of their treatment, and that most of the expense of providing and maintaining the state hospitals is borne by the taxpayers. That being the case, it is decidedly unfair to the taxpayers of New York to be burdened with the expense of caring for insane citizens of other states and countries. It is the duty of each state to provide for its own unfortunates and to leave the unfortunates of other states to be cared for by the states of which they may be citizens.

This general principle requires some modification in practice. Since the hospitals do have a custodial function to fulfill it is in the interest of the people of the state that the hospitals protect them from insane aliens and non-residents as much as from insane citizens of the state. But this protection can be afforded just as well by removing the dangerous person from the state as by caring for him in a hospital. The removal of such persons to the proper jurisdiction should be undertaken as soon as possible. Meanwhile care in the state hospitals is indicated.

There is also a small percentage of the admissions to the state hospitals whose citizenship and residence cannot be ascertained.[1] Obviously these persons must be cared for by the state where they are found to be insane, at least until such time as their citizenship can be determined.

It occasionally happens that a person found to be insane in New York has not been there long enough to establish a legal residence and is not entitled to care according to the laws of any other state. It has been the practice of one or more states in the past to send such patients in the care of an attendant to the state of their last known residence and desert them there without making any provision for their further care.[2] New York has followed the more humane policy of caring for all such patients unless some other jurisdiction agrees to provide care.

Again, when an alien has lived in a foreign country for a long time, even though he has not become a citizen of that country, it is probable that he has formed ties there and has contributed as much to the welfare of the community as have its citizens. Such pseudo-citizens should probably be treated the same as if they were citizens, at least in respect to their admission to and care in the state hospitals.

Except for the above modifications in the interest of humanity and to protect the people of the state, the only rule fair to the taxpayers of the state appears to be that the state hospitals be open only to citizens of New York, and that other persons found insane while within the state be returned to the place of proper jurisdiction for care.

B. *The Bureau of Special Examination; Organization and Powers*

New York State has set up the Bureau of Special Examination to apply this rule. The organization, powers and duties of this bureau are described in Section 23 of the Mental Hygiene Law.[3] The head of the bureau is a medical examiner who

[1] Two and four-tenths per cent of first admissions to the New York state hospitals in the year ending June 30, 1928, according to the *Fortieth Annual Report of the Department of Mental Hygiene*, p. 159.

[2] Notes of interview with Dr. Spencer L. Dawes, medical examiner of the Department of Mental Hygiene, January, 1928.

[3] Chapter 426, *Laws of 1927*.

"shall be a reputable physician, a graduate of an incorporated medical college, of at least ten years' actual experience in the practice of his profession, and of at least five years' experience in the care and treatment of the committed or alleged insane in the New York state hospitals, or elsewhere."[4]

There are at present one deputy medical inspector, two transportation agents, and a secretary in the bureau.

The powers and duties of the bureau are as follows:

"Such bureau shall maintain a careful inspection and observation of the methods and facilities for examining immigrants for mental disease and defect at the port of New York, and shall, from time to time, report to the commissioner upon the methods employed, and their efficiency, and shall render reports regarding the prevalence of insanity, epilepsy and mental defectiveness among aliens and the foreign-born population of the state and shall make suitable recommendations as to means by which insane, epileptic and mentally defective aliens may be deported or returned. Such bureau shall examine and inspect alien and non-resident insane, epileptic and mentally defective persons, and alleged insane, epileptic and mentally defective persons in state and other public institutions and elsewhere where such persons and alleged insane, epileptic and mentally defective persons may be, for the purpose of determining whether they are suitable cases for deportation under the immigration law, or removal under the provisions of this section to other countries or states. The superintendents, or persons in charge of such institutions or other places shall notify such bureau of all such cases coming under their jurisdiction and shall furnish all aid and information possible to accomplish the deportation or removal of such aliens and non-residents. The bureau shall notify the proper authorities having control of the enforcement of the immigration laws at the ports of entry of such immigrants as are found to be insane, idiotic, imbecile, mentally defective or epileptic, and such insane aliens as are or become public charges, or who are in the country in violation of law, and shall arrange for their deportation in accordance with the provisions of such laws. In the case of non-residents they shall notify the commissioner of the location of the same and in all suitable cases the commissioner shall grant the bureau the necessary authority for the investigation and removal of such non-resident insane persons, mental defectives or epileptics. The bureau may, upon the request of any indigent insane persons, mental defectives or epileptics, or the written consent of their relatives, legal representatives, or qualified friends, subject to the approval of the com-

[4] *Ibid.*, sec. 23.

missioner, remove such patients to any country, state or place to which they may properly belong. In making such transfers and removals the bureau shall, so far as is practicable, employ nurses and shall employ female nurses or attendants to accompany female patients unless it is certified by the superintendent that such patients are in condition to travel alone with safety. The duties hereby imposed upon such bureau shall be performed under the supervision of the commissioner, and in accordance with rules adopted by him. The commissioner may impose such other duties on such bureau as he may deem necessary and proper for carrying out the general purposes and intent of this section, and may also from time to time, when necessary, detail the medical examiner or a medical deputy of said bureau to perform the duties of the medical inspector. The medical examiner and deputies of such bureaus shall be empowered to administer oaths when necessary to persons giving information relative to cases under investigation."[5]

To facilitate the work of the bureau

"the commissioner shall endeavor to arrange for the continued official recognition of such bureau by the proper authorities of the United States and other states for carrying out the purposes of this section."[6]

Also, the

"commissioner may make reciprocal agreements with other states or political subdivisions thereof to provide for the prompt and humane return under proper supervision of insane, epileptic and mentally defective residents of either state."[7]

C. *The Work and Accomplishments of the Bureau of Special Examination*

It has been seen that the Bureau of Special Examination is authorized to do three things, namely:—to bring about the return of certain persons to the states of which they are residents; to repatriate certain aliens; and to investigate and advise upon allied matters. The bureau has been active in each of these fields.

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[5] *Ibid.*
[6] *Ibid.*
[7] *Ibid.*

The return of non-resident patients to the states of which they are residents is greatly facilitated by the reciprocal agreements which the commissioner is authorized to make.[8] The agreement with Massachusetts is typical of these.[9]

> "Reciprocal arrangement for the exchange of persons suffering from mental disease, mental defect or epilepsy, entered into by the Department of Mental Diseases of the Commonwealth of Massachusetts and the Department of Mental Hygiene of the State of New York.

"(1) The term 'resident' as used in this agreement shall be a person who has lived continuously in either state for a period of at least two years and, subsequently to acquiring such a residence in either state, has not acquired a residence in any other state by living continuously for two years in such other state; provided that time spent in an institution or on parole from an institution for the insane, mentally defective or mentally incompetent epileptics shall not be counted in determining the time of residence in a State.

"(2) All insane, mentally defective, or mentally incompetent epileptic residents of either State shall be promptly accepted by the duly constituted authorities of such state.

"(3) In certain cases where the relatives or legal guardian or committee or persons legally liable for the maintenance and support of the patient are residents of either state, and some member of the family, or the ward of such guardian or committee, acquires a residence as defined in this agreement in the other state and becomes a public charge because of insanity, mental defect or mental incompetency because of epilepsy, for the convenience of the relative and for humanitarian reasons, the person may be accepted by the duly constituted authorities of the state in which such relatives, etc., reside.

"(4) Each hospital or institution in each state shall accept promptly persons paroled by such hospital or institution when returned by the proper authorities of the other state during the period of the parole.

"(5) For the purposes of this agreement, the residence of a minor shall be considered the same as the residence of the parents, and the residence of a married woman shall be considered the same as that of her husband.

"(6) Accurate and detailed histories are to be presented by each state in asking for the acceptance of a patient.

"(7) No person is to be transferred from one state to the other who is not in condition to travel without danger to himself or to others, such transfers,

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[8] See above, quotation from Sec. 23 of the *Mental Hygiene Law.*
[9] *Handbook of the Department of Mental Hygiene*, 1928, pp. 269–271.

however, to be made as soon as the mental and physical condition of the patient warrants.

"(8) In returning an accepted patient under this agreement, the state making the return shall bear all of the expenses incurred and the patient shall be accompanied in every case by an authorized agent of the state making the return to the place designated by the authorities of the state to which the patient is returned.

"(9) By mutual consent, in any particular case not covered by the terms of this agreement, it may be modified to meet the special conditions.

"(10) This agreement, duly signed by the Commissioner of the Department of Mental Diseases of the Commonwealth of Massachusetts and the Commissioner of the Department of Mental Hygiene of New York, shall remain in force as long as may be agreeable to both parties, but may be terminated by three months' notice by either party.

"It is understood and agreed between the contracting parties that nothing in this agreement is to be construed as applying to inmates of correctional or penal institutions in the respective states.

"This agreement supersedes a former agreement dated May 1, 1925.

November 15, 1927.

Department of Mental Diseases,
The Commonwealth of Massachusetts
By Geo. M. Kline,
Commissioner.

Department of Mental Hygiene,
State of New York
By F. W. Parsons, M.D.
Commissioner."

Similar agreements are usually in effect with from ten to twelve states.[10] The number varies from time to time because the agreements are not always renewed as soon as they expire. In the absence of such an agreement it is usually possible for the bureau of special examination to reach an agreement with the state of which the patient concerned is a resident to accept responsibility for his care by presenting a complete history of

[10] According to the *1929 Handbook of the Department of Mental Hygiene* there were nine such agreements in effect at the time of publication and negotiations for four others were pending. In 1928 there were 11 in effect at the time the *Handbook* was published.

the patient showing the facts as to his residence in the state. There are, however, a few states, particularly in the South, which fail to cooperate at all to provide for the care of their citizens who become insane elsewhere.[11] Fortunately for New York, there are few patients who would be transferable to those states anyway.

The activities of the bureau during the fiscal year ending June 30, 1928, resulted in the removal from the state of 951 non-residents, of whom 637 were removed at the expense of friends and 314 at the expense of the state. During the ten-year period, 1919–1928, total removals of non-residents amounted to 6,139. 3,783 of these were removed at the expense of friends and 2,356 at the expense of the state.[12]

At the same time there were a great many patients returned to New York from other states, but apparently not as many as were sent away.[13] However, since these patients would be returned to New York in any case, the saving to that state is measured by the total number of non-resident patients which the bureau was able to send to other states.

When the bureau is dealing with a citizen of the United States who is not a resident of New York its power is limited only by the necessity of securing the consent of the state where the patient belongs. As has been indicated, this is not usually difficult. When the case of an insane alien is under consideration however, the situation is complicated by the laws of the United States and of the foreign state of which the patient is a national, or from which he came to the United States.

In attempting to relieve the state of the expense of caring for insane aliens there are two procedures which the bureau of special examination can follow. First, the bureau may secure the deportation of certain aliens by the federal government. Second, it may make possible the return to other countries of insane patients who are willing to return but are incapable of

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[11] Note of interview with the medical examiner, Dr. Dawes.

[12] Statistics from the *Fortieth Annual Report of the Department of Mental Hygiene*, p. 94.

[13] Statistics on this point are not computed by the state but this view was expressed by the medical examiner.

meeting the necessary expenses. These persons may be returned either at the expense of New York or of their friends from whom help is solicited by the state.

There are certain difficulties which must be overcome in either case. When an insane alien is unwilling to leave the United States it is necessary to determine whether he falls within any of the classes which are deportable under federal law. The pertinent sections of the immigration laws are as follows:

"Sec. 19. That at any time within five years after entry, any alien who at the time of entry was a member of one or more of the classes excluded by law; any alien who shall have entered or who shall be found in the United States in violation of this act, or in violation of any other law of the United States; * * * * any alien who within five years after entry becomes a public charge from causes not affirmatively shown to have arisen subsequent to landing; * * * * shall, upon the warrant of the Secretary of Labor, be taken into custody and deported; * * "[14] Sec. 3. "That the following classes of aliens shall be excluded from admission into the United States: All idiots, imbeciles, feeble-minded persons, epileptics, insane persons; persons who have had one or more attacks of insanity at any time previously; persons of constitutional psychopathic inferiority; persons with chronic alcoholism; * * * * persons likely to become a public charge; * * *"[15]

Section 23 of the Immigration Act of February 5, 1917 provides, among other things, that

"It shall be the duty of the Commissioner General of Immigration to detail officers of the Immigration Service from time to time as may be necessary in his judgment to secure information as to the number of aliens detained in the penal, reformatory, and charitable institutions (public and private) of the several States and Territories, the District of Columbia, and other territory of the United States, and to inform the officers of such institutions of the provisions of law in relation to the deportation of aliens who may become public charges."[16]

Such a survey was made in January, 1927. It showed that there were then in the continental United States, Alaska, Hono-

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[14] *Immigration Act of February 5, 1917* (39 Stat. 874), sec. 19.
[15] *Ibid.*, sec. 3.
[16] *Immigration Act of February 5, 1917* (39 Stat. 874), Sec. 23.

lulu and Porto Rico 34,470 insane aliens in hospitals and other institutions for their care, and a total of 113,105 aliens who were public charges.[17]

It remains for the bureau of special examination to assemble the evidence to show whether or not an insane alien falls within one or more of the deportable classes. When the bureau finds that an alien is deportable it certifies its findings to the immigration officials at the port of entry, who, in turn, investigate and if they are convinced of the correctness of the findings apply to the Department of Labor for a warrant of arrest.[18] Thereafter, the disposition of the case lies with the federal officials.

In the ten years from July 1, 1918 to June 30, 1928, the bureau has certified 2,976 aliens as deportable, 2,346 of whom have been deported.[19] The fact that in this period the Department of Labor has failed to deport 21.2 per cent of the aliens whom the bureau has held to be deportable after careful investigation has caused the medical examiner to charge that:

"The two leading causes for the cancellation of such warrants and the failure on the part of this administration to deport those whose deportation the law requires, even after their deportation is legally ordered, is lack of funds and political pressure upon the department by Representatives and Senators and other influential political personages, mainly from the cities filled with the foreign-born."[20]

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[17] U. S. Department of Labor, *Annual Report of the Commissioner General of Immigration*, 1927, p. 11.

[18] For details of the procedure of arresting and deporting aliens on warrant see "U. S. Department of Labor," *Immigration Laws and Rules of January 1, 1930*, Rule 19,—Arrest and Deportation on Warrant, pp. 162–170. The information which the bureau of special examination should assemble is specified in subdivisions B and C, on page 163.

[19] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 94.

[20] Spencer L. Dawes, M.D., Medical Examiner, New York State Hospital Commission (now the Department of Mental Hygiene), *Immigration and the Problem of the Alien Insane*, pp. 8–9. Reprinted from the *State Hospital Quarterly*, February, 1925. The Hon. Peter F. Snyder, Assistant to the Secretary of Labor, in an interview February 6, 1930, asserted that while such political pressure is frequently brought to bear it is unavailing because the Department of Labor has no choice but to order deportation in cases where it is clear that the alien is within the deportable classes. He stated further, however, that since the law does not state how soon the Department shall cause an alien to be deported, the deportation proceedings are sometimes postponed when the law appears to apply unjustly. As an illustration he cited the recent case of Edward N. Crosbie, one of the persons who had been

If this charge could be substantiated and the condition which it describes corrected it would result in a great saving to the State of New York. It is sufficient for our purposes to point out that the bureau of special examinations is doing everything in its power to call to the attention of the federal government the facts in regard to aliens who come within the deportable classes.

The repatriation of patients, regardless of whether they are deportable, who are desirous of leaving this country, is a very important part of the bureau's work. During the same ten-year period between July 1, 1918 and June 30, 1928, when the bureau brought about the deportation of 2,346 insane aliens, it also repatriated 1700. 1,023 of these were removed from the state at the expense of friends and 677 were removed at the expense of the state.[21]

In the matter of repatriating insane aliens, the bureau is severely hampered by the attitude of most foreign governments regarding the granting of passports for the return of their insane nationals. For instance,

"The Italian government no longer permits a passport to be issued until the entire case has been submitted to Rome for investigation as to citizenship, birth, financial responsibilities of the alien and his relatives in Italy, the willingness of the friends in Italy to assume responsibility and an authorization from the local authorities for the alien's return. All this, if successful, requires months."[22]

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certified by Dr. Dawes as being within the deportable classes. Crosbie was born in Canada but was brought to the United States with his family when still an infant. After having lived here about twenty years without being naturalized he suffered a mental breakdown for which he was treated in one of the state hospitals. His treatment was paid for by his family. At that time his history was investigated and it was found that he was not deportable because he had resided in the United States more than five years and had entered the country legally. Sometime later during an outing he spent a few hours in Canada. Subsequently he was arrested because his previous attack of insanity placed him in the class of aliens mandatorily excluded from entry. Although legally subject to deportation he has been granted an indefinite stay of execution of the order. The correct solution of this case would seem to be a change in the law which would legalize the action which the Department of Labor is taking under rather dubious authority.

[21] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 94.

[22] *Thirty-eighth Annual Report of the State Hospital Commission*, p. 77.

Earlier reports of the medical examiner show the existence of similar difficulties in repatriating insane aliens to nearly all countries except Great Britain.[23]

The work of the bureau of special examination is growing with the increase in the hospital population. It investigated 1,603 cases in 1919 and 2,598 in 1928, the increase being fairly regular from year to year. The grand total of removals brought about by its activities has also increased from 488 in 1919 to 1,441 in 1928, but this increase has been made up for the most part of non-residents rather than of aliens.[24] The results of the bureau's work during the year ending June 30, 1928, may be summarized as follows:—313 aliens deported; 177 other aliens repatriated; 951 non-residents removed to other states; in all 1,441 persons removed from the state.[25] 371 of these were removed at the expense of the state.

The medical examiner has been very active in fulfilling the third function of his office, namely, investigating the working of the immigration laws and making recommendations concerning them. His findings and a record of his activities are given in his annual reports to the Department of Mental Hygiene.[26] The principal weaknesses in the present laws stressed in these reports are the inadequacy of federal appropriations for officers to determine as to the mental condition of immigrants, the inadequacy of federal agents to investigate all of the cases certified as deportable by the bureau, the need for having applicants for visas passed upon by an American medical officer before the visa is granted, the need for penalizing steamship companies which bring insane aliens to this country, the weaknesses in the laws respecting alien seamen, etc.

Similar activities of the medical examiner in attempting to determine and have adopted the most favorable provisions for

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[23] The annual reports of the medical examiner are printed in the annual reports of the Department of Mental Hygiene and its predecessor, the State Hospital Commission.

[24] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 64. On this page is given a summary of the work of the bureau since 1894.

[25] *Ibid.*, p. 94.

[26] E.g., *Thirty-third Annual Report*, pp. 69–72; *Thirty-fourth*, pp. 75–79; *Thirty-fifth*, pp. 68–71; *Thirty-sixth*, pp. 76–80; *Thirty-seventh*, pp. 87–91; *Thirty-eighth*, pp. 77–79; *Thirty-ninth*, pp. 79–80; *Fortieth*, pp. 92–94.

minimizing the number of insane aliens who would become a burden upon the state have included appearing as a witness before the House Committee on Immigration and Naturalization,[27] calling a conference on immigration which was attended by representatives of ten states where the alien insane constitute a serious problem and which drew a list of recommendations to present to their Senators and Representatives,[28] and a study of the working of the new federal law requiring the examination of immigrants abroad, conducted at his own expense.[29]

It is evident that while the federal government makes and applies the laws as to who shall be permitted to enter and stay in the United States, the state is actively attempting to defend its own interests.

D. *The Value of the Work of the Bureau of Special Examination*

In the preceding pages, the work of the bureau of special examination has been spoken of as justified purely on the theoretical assumptions that New York State is under no obligation to certain aliens and other non-residents, and that the care of these persons should not be undertaken by the State unless it is impossible to do otherwise. While these assumptions are sound it would not be to the State's advantage to act upon them unless it can be shown that the State saves money thereby.

It is easy to show that the work of the bureau results in a very substantial saving to the taxpayers. In the year ending June 30, 1928, the bureau caused 1,441 persons to be removed from the state. 975 of these were in state hospitals, 344 were in city and county hospitals pending commitment to a state hospital, 104 were in a hospital of the Veterans' Bureau, and 18 were elsewhere. It may be assumed that 1,337 of these persons, or all but 104 in the Veterans' Bureau hospital, would have been main-

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[27] *Thirty-fifth Annual Report of the State Hospital Commission*, p. 69. At this hearing the medical examiner proposed that immigrants be given an examination at the ports of embarkation rather than the ports of entry, which proposal was adopted.

[28] *Thirty-sixth Annual Report of the State Hospital Commission*, pp. 77–79. These recommendations were presented to the House Committee on Immigration and Naturalization but were not acted upon.

[29] *Thirty-seventh Annual Report of the State Hospital Commission*, pp. 89–90.

tained sooner or later in a state hospital or other state institution.

The per capita cost of maintenance in the state hospitals that year was $404.82.[30] To this should be added an item of $280.00 to cover interest and depreciation on the state's investment per patient.[31] Thus the gross cost to the state per patient was $684.82. Reimbursing patients in the state hospitals that year paid the state $1,862,244.98, which amounted to $42.62 per resident patient.[32] Although it does not seem likely that the average reimbursement rate paid by alien and non-resident patients was as high as the general average rate, this amount may be deducted from the gross cost per patient, to give approximately the net cost per patient for the year. This would be $642.20 per patient.

If the 1,337 persons removed from the state by the bureau of special examination had spent an average period of one year in the state hospitals, the cost to the state would have been $858,621.40. From what statistics are available it would appear that the average duration of hospital life is closer to two or three years.[33] The saving to the state effected by the removal of these persons is correspondingly greater.

Compared to the saving which results from its work, the expense of maintaining the bureau of special examination is insignificant. In 1928, these expenses were:—for salaries, $15,950;[34] for repatriation and transfers, $32,994.79;[35] in all, $48,944.79. Thus if the average duration of hospital life of the patients removed were only one year, the work of the bureau would save the taxpayers of the state more than eight hundred thousand dollars a year.

E. *The Foreign-born Insane*

Any discussion of the problems connected with the presence of alien insane in a state would be incomplete without some

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[30] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 16.
[31] See above, pp. 7–8.
[32] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 94.
[33] Pollock, *op. cit.*, p. 190. "More than one-half of the patients who enter our civil State Hospitals finally die therein. The average period of hospital life of those who die in the hospitals is between six and seven years.
[34] Appropriations, Chapter 55, *Laws of 1927*.
[35] Department of Mental Hygiene, *Fortieth Annual Report*, p. 16.

reference to the broader questions connected with the presence of the foreign-born insane. A few statistics will show the magnitude of these problems.

39.1 per cent of the patients admitted to the New York State hospitals in the year ending June 30, 1928, were of foreign birth and the citizenship of 2.3 per cent was unknown. Of the 4,250 patients known to be of foreign birth, 2,066 had been naturalized but 2,184 were still aliens.[36]

Of the resident patients in the state hospitals June 30, 1928, 20,209, or 41.6 per cent of the total, were of foreign birth. 11,661, or 24.0 per cent of the total, were still aliens.[37]

In 1923, the Bureau of the Census made a study of patients in hospitals for mental disease in the United States.[38] At that time the rates per 100,000 of general population of the same nativity and parentage were,—for native white patients for the United States as a whole, 209.9; for foreign-born white patients, 513.9. For New York the rates were,—for native white patients, 312.6; for foreign-born white patients, 589.9.[39]

These statistics show that insanity is more common among the foreign-born population of the United States than among the natives, and raise the question as to whether it is unavoidable that these thousands of foreign-born persons be cared for in our state hospitals, mostly at public expense, or whether anything can and should be done about it.

Most of the responsibility for this situation rests with Congress and the federal government for they alone can say who may enter the country and who shall be deported. It has been seen that the state is doing what it can under federal laws to relieve itself of the expense of caring for those who are deportable. Even so, if more than 40 per cent of the patients in the state hospitals are of foreign birth, they are costing the state in the vicinity of ten million dollars a year.

Moreover, besides placing a great expense upon the states,

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[36] Department of Mental Hygiene, *Fortieth Annual Report*, p. 120.
[37] *Ibid.*, p. 211.
[38] Department of Commerce, Bureau of the Census, *Patients in Hospitals for Mental Disease*, 1923, Government Printing Office, 1926.
[39] *Ibid.*, p. 120.

it is conferring a doubtful benefit upon thousands of immigrants to let them into the country if they are to spend most of their lives in hospitals for the insane thousands of miles from their friends. These two considerations call for the exercise by the federal government of every effort to exclude all would-be immigrants who are likely to become mental patients.

This general principle has been recognized by Congress and was incorporated in the Immigration Act of February 5, 1917,[40] which excludes from admission into the United States insane persons, persons who have had one or more attacks of insanity at any time previously, and persons of constitutional psychopathic personality.[41]

It has been repeatedly pointed out, however, that the enforcement of this act has been weak, principally because insufficient funds have been appropriated to provide an adequate field staff.[42] In the general interest Congress should be more liberal in providing for the enforcement of this law, for the saving to the states would more than offset the added expense to the national government.

It has also been charged that political influence has been invoked to bring about the illegal entry of many persons of these excluded classes.[43]

The Immigration Act of 1924, besides materially reducing the total influx of immigrants, has done much to make the enforcement of the excluding provisions of the Act of 1917 more effective.[44] According to this law every prospective immigrant must secure an immigration visa from an American consul before leaving for the United States.[45] To secure this he must swear that he is not a member of any of the excluded classes

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[40] 39 Stat. 874.

[41] *Op. cit.*, sec. 3.

[42] See for example, the recent annual reports of the Commissioner General of Immigration. See, also, Victor Safford, *Immigration Problems*, especially chapters eleven and twelve; and also, Dr. Spencer L. Dawes, *Immigration and the Problem of the Alien Insane*, pp. 4–5, in which he quotes several authorities and says, "I myself saw immigrants arriving at practically the same rate, and noted them at the rate of seven and a fraction seconds per examination."

[43] See Safford, *op. cit.*, and Dawes, *op. cit.*

[44] 43 Stat. 153, especially sections 2 and 7.

[45] *Ibid.*, sec. 2.

He must also present a certificate from a reputable physician, who may be designated by the consul, to the effect that he is not afflicted with any of the diseases which warrant exclusion.[46] Members of the immigration service and of the Public Health Service have been designated to advise the consuls in the countries from which the bulk of immigrants come. Finally, the immigrant is still subject to rejection by the immigration officers at the port of entry although in recent years few have been so rejected.[47]

It is exceedingly doubtful as to whether it would be profitable for the national government to take any further measures to ascertain which would-be immigrants are going to be found insane subsequent to their arrival. This is true at least in respect to immigrants from all places except the contiguous countries. The reports of the Commissioner-General of Immigration have repeatedly called attention to the fact that his forces are inadequate to cope properly with the situation along the land borders of the United States.

If the national government can, or will, do nothing more to sift out from the stream of immigrants those who are likely to become public charges, is there anything that the state can do to cut down the number of these persons who must be cared for in its state hospitals? If the state can do anything it will be in the nature of measures designed to remove the factors which lead to the development of advanced psychoses such as require hospital treatment. Since Chapter Five is devoted to this general topic, further discussion of this subject will be deferred until then.

F. *Summary*

This chapter has shown:

1. Who are, and who are not, entitled to care in the New

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[46] *Ibid.*, sec. 7. See also U. S. Department of State, *Admission of Aliens into the United States, General Instruction Consular*, March 23, 1929, Government Printing Office, 1929.

[47] The annual reports of the Commissioner-General of Immigration for 1928 and 1929 point out that almost the only immigrants now excluded at ports of entry are stowaways and seamen, but many aliens are excluded along the land borders of the U. S.

York state hospitals, in so far as residence and citizenship are concerned. In brief, those not entitled to such care are aliens of brief residence in the United States and legal residents of other states.

2. That such persons should be removed to the place of proper jurisdiction whenever possible.

3. That the bureau of special examination has been established and given power to apply this principle.

4. That this bureau has succeeded in removing several thousand aliens and non-residents from the state and, by making investigations and recommendations, has aided in securing several changes in federal laws such as to protect the interests of the state.

5. That the work of this bureau results in a saving of several hundred thousand dollars a year to the taxpayers of New York.

6. That insanity is more common among the foreign-born than among natives but that since the sifting out of undesirable would-be immigrants is a function of the national government, the state can only present its case and work for federal action.

7. That the immigration laws provide for the exclusion of the right classes of persons but that insufficient appropriations have weakened the value of these provisions.

8. That the Act of 1924 has introduced desirable innovations from which much relief may be hoped for after they have been in operation a sufficient length of time. As yet sufficient time has not elapsed to disclose the degree of their effectiveness.[48]

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[48] 67.9 per cent of the foreign-born first admissions to the New York state hospitals during the year ending June 30, 1928, had been in the United States 15 years or more prior to the time of their admission. Only 344, or 9.4 per cent, had been in the United States less than five years. See *Fortieth Annual Report of the Department of Mental Hygiene*, p. 158). Since only aliens who have been in the country less than five years are deportable (unless they entered illegally), it is evident that only a very small proportion of the aliens in the state hospitals can be deported no matter how effective an organization is set up for the purpose. These figures also show that the results of the new system of selecting immigrants will not be fully evident for another ten years. They also show what a small percentage of the foreign-born admissions to the state hospitals are subject to deportation. Finally, they suggest the difficulty of detecting persons who will be insane some fifteen years later.

IV

The Employment of Insane Patients Considered as a Means of Reducing Public Expenditures for Their Care

A. *Development of the Systematized Direction of Patients' Abilities into Productive Channels*

There have been three steps in the development of the use of the ability of patients to perform useful tasks. Early institutions for the insane, as was pointed out in Chapter One, were no more than convenient places for disposing of the insane so that they would not be a menace to the community. The aged and infirm were generally kept in poorhouses, while more active patients were as a rule kept in jails and prisons where they were kept in chains or in various other types of mechanical restraining apparatus.[1] In neither case were insane patients expected to engage in useful activities, nor was any provision made so that they could do so.

So long as these conditions were typical the cost of caring for the insane was not offset at all by the results of their ability to work. Furthermore, the inhuman treatment to which the insane were subjected aggravated their condition so much that they would require more care and for longer periods.

Shortly before 1800 Pinel in France, Benjamin Rush in the United States, and a few others began to call attention to the fact that patients who were occupied were more tractable than those who were kept chained up without any opportunity for exercise or diversion. Since then progress toward providing occupations for all patients has been steady though slow. This second period was characterized by the employment of some of the more able-bodied and willing patients in various activities, connected with the operation of the hospitals. Meanwhile

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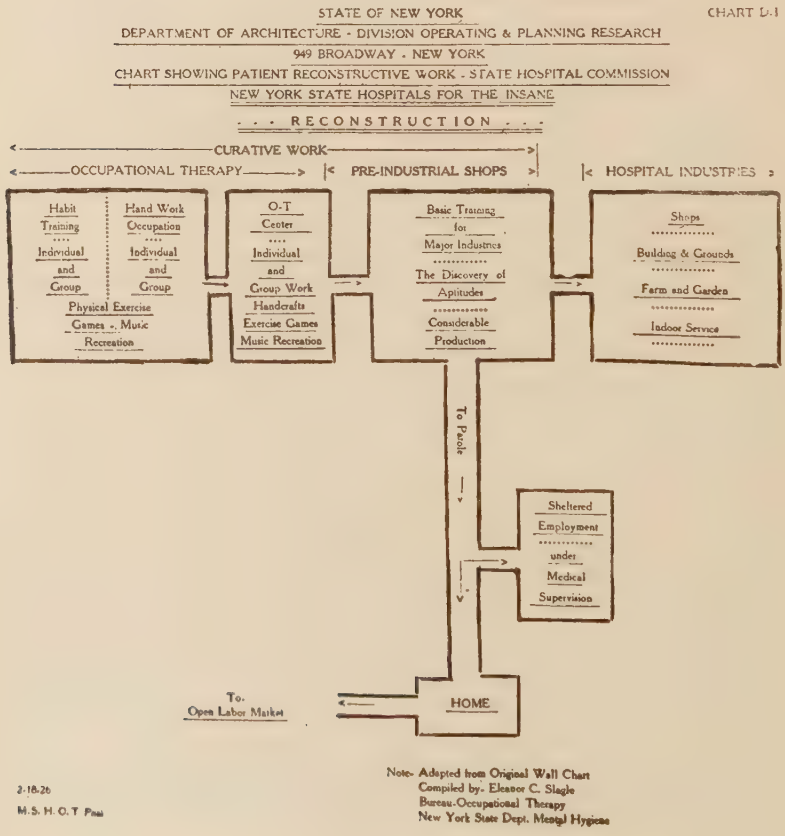
[1] *The Institutional Care of the Insane in the United States and Canada*, 4 Vols., edited by H. M. Hurd, M.D., is the most complete and authoritative source of information as to the history of the care of the insane in the United States.

observations continued to pile up to the effect that the work of these patients contributed toward the cost of operating the hospitals and, what is even more important, that providing mental and physical occupations for the insane is one of the most potent means of improving the patients' condition.

The third step in the utilization of patient activities has been based upon this knowledge. This has been a development confined almost entirely to the last twenty years, but in that time it has made progress so that its desirability is universally recognized. This is what is now known as occupational therapy.



It may be defined as a system of providing occupations for all patients, prescribed according to their individual capacities and needs as a coordinated part of their hospital treatment. It is primarily a method of therapy but its adoption has been followed by certain economies which are solely attributable to it.

The chart opposite page 73, prepared by the director of the Bureau of Occupational Therapy of the New York Department of Mental Hygiene[2] furnishes a complete picture of the organized occupational activities of patients in the New York state hospitals,—both those activities which result directly or indirectly in economies in management, and those which from a financial viewpoint cost more than they save.

B. *The Nature and Extent of Economies Due to the Utilization of Patient Labor*

The most obvious saving due to the employment of patients is from the group of activities listed as hospital industries. There is little that is new about the conduct of these industries, however. For several decades there has not been a hospital for the insane with any claim to being progressive that has not had such industries as these developed to a greater or less extent.

In one important respect there has been a change here, however. Whereas formerly the assignment of patients to this sort of work was more or less haphazard, since the recognition of the value of occupational therapy there has been a tendency to find work for all patients whose condition makes it advisable, and to suit the work as far as possible to the needs of the individual patient.

Statistics as to the value of the patients' work are incomplete. Some light is thrown on this point, however, by the following. The wholesale value of products of state hospital farms in 1927 was $787,931.02. Wages of paid employees, feed, seed, fertilizers and supplies amounted to $516,766.46, leaving a net profit of $271,164.56 from the operation of the farms.[3] The same year the hospitals purchased garden products, potatoes, fruit, field crops, milk and eggs to the value of $1,129,762.44[4]

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[2] Mrs. E. C. Slagle.
[3] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 83.
[4] *Ibid.*, p. 85.

There is also available an estimate as to the value of products manufactured by the patients. In the year ending June 30, 1927, the value of these products was $603,966.07.[5] The industries vary somewhat from one hospital to another but in each the most important are the manufacturing of shoes and clothing. Other hospital industries commonly engaged in are chair caning, making reed furniture, upholstering, mattress making, and the manufacturing of brushes and brooms. At the Utica State Hospital are located the state hospital press which publishes nearly all of the many reports and periodicals published by the department, a plant for roasting coffee and spices for all the hospitals, a knitting plant, and a plant for making brooms, brushes and mats.

In addition to the patients who work in the shops and on the farms there are hundreds who are occupied in performing tasks essential to the operation of the hospitals. The simplest of these are such monotonous tasks as running floor polishers up and down the corridors. While this activity does not contribute much toward the upkeep of the hospitals it does furnish an outlet for patients of the more active sort who are yet unable to concentrate on more involved duties.

From these very simple tasks the nature of the work performed shows every variation of complexity from cleaning the wards to making and repairing furniture or, for the female patients, fine embroidering. Other patients are engaged in dish washing, helping to prepare meals, serving in the dining rooms, washing and ironing and similar tasks connected with housekeeping. Out of doors, in addition to the farming operations, many patients are kept busy in the kitchen gardens, in building roads, digging ditches, carting cinders, planting shrubs and otherwise beautifying the grounds. A few patients are assigned to the carpenter shops, to painting, to mechanical work and plumbing, to the engine house and, in fact, to any duties connected with the operation of the hospitals when there are patients whose capacities are equal to the work.

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[5] *Handbook of the Department of Mental Hygiene*, 1928, p. 349.

While statistics as to the value of the work performed by patients in the shops and on the farms are incomplete, they are nonexistent in regard to these other activities. It is obvious that if these things were not done by patients most of them would have to be done by paid employees. But there is no comparison between the efficiency of patients and employees. As it is, the presence of many employees is necessary to supervise the work of the patients and, for that matter, to work with them, so that it would be almost impossible to arrive at any accurate estimate of the value of the work performed by the patients. It is almost certainly, however, worth at least a million dollars a year and perhaps two or three times that much.

The most tangible economies in the operation of the hospitals result from the employment of patients in those industries where they are able to produce goods which are needed for the operation of the hospitals or to furnish services which would otherwise have to be paid for. There are, however, certain more intangible economies due to their employment which are probably of at least equal importance.

These intangible, or indirect, economies are of two kinds. First, there is the saving to the state which is brought about by the early discharge or parole of patients who would not be removed from the hospital as soon as they are if it were not for the improvement in their condition brought about by their engaging themselves in mentally beneficial activities while in the hospitals. It is a universally accepted fact among psychiatrists that occupations for the insane do more than almost any other single means of curative treatment to bring about improvement.[6] Thus by reducing the number of patients who remain in the hospitals the practice of employing patients in useful pursuits very materially contributes to reducing the cost of providing for the insane.

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[6] On this point see C. A. Potter, M.D., *Development of Occupational Therapy in Gowanda State Hospital*; W. C. Garvin, M.D., *The Financial Aspect of Occupational Therapy*; O. O. Fordyce, *Occupational and Recreational Therapy for Mental Patients*; M. L. Putnam, *Occupational Therapy in Relation to Dementia Praecox*; H. M. Pollock, *Development of Occupational Therapy in the New York State Hospitals*; and annual reports of nearly any progressive hospital for the insane.

In the second place, occupational therapy serves to make the patients who remain in the hospitals less destructive of property and more orderly so that they require less supervision by paid employees.[7] There are always in the hospitals a certain number of deteriorated patients who, if left to themselves, will tear up their clothing and bed sheets and whatever else they come upon. Patients of this sort who can be taught to turn their energies to picking apart rags or burlap do not, of course, produce anything of much material value but they are kept from other destructive activities.

Reference to the chart opposite page 73 will show that the first classes in occupational therapy are in habit training. To a certain extent these classes are successful in reeducating deteriorated patients but they are of even more value in fixing proper habits so as to prevent deterioration in young patients, or at least to postpone it. While the products of these classes have as a rule very little economic value, there are nevertheless certain economies effected by them. Thus, for example, it is a matter of record that the amount of laundry soiled by deteriorated patients is substantially decreased following a course in habit training. Also, the improved habits of the patients relieve the attendants of a great amount of very distasteful nursing.[8]

It being the function of the state hospitals to cure or improve the condition of patients rather than to operate at a profit, the needs of the individual patient are rightly placed ahead of the economic value of his work. It is fortunate, therefore, that it is generally good therapy to have the patient occupied on work which has economic value. In the preindustrial shops patients are taught to make cement blocks and posts, willow furniture and a variety of toys and similar easily made articles. Female patients are trained to weave curtains and other articles needed in the hospitals, to embroider and to do other kinds of needlework. Less advanced classes perform simpler operations such as winding balls of yarn made from burlap and other

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[7] See, especially, the report of the director of occupational therapy in the *Thirty-eighth Annual Report of the State Hospital Commission*, p. 86; also Putnam, M. L., *op. cit.*

[8] *Ibid.*

waste material which had been picked apart and tied into strings by still more deteriorated patients. Similarly, the less advanced classes for men perform such operations as sandpapering the pieces of toys which are later glued together and painted in the other classes.

Except as some of the articles made in these classes can be used in the institutions their work brings in only about enough revenue to pay for new materials in addition to the waste materials which are used as far as possible.

The expense of the personnel of occupational therapists needed to instruct all of these classes is another important factor in determining whether they are an asset or a liability economically. It has already been pointed out that the training in these classes benefits the patients so that they require less supervision on the wards. On the other hand, while they are in their classes they require the supervision of more highly trained employees than the ordinary run of ward attendants. As to what extent these two facts offset each other no definite study has been made. It does not appear that the cost of having occupational therapists is materially greater than that of having a slightly greater number of ward attendants. In any case there is no doubt but that the other economies traceable to the presence of occupational therapy much more than make up for any extra cost of this kind.

In summary, then, the practice of employing patients in profitable industries whenever their condition does not render this impossible results in a very important diminution of the cost of providing for their care. This direct saving is accomplished by their production of goods needed for the operation of the hospitals and by their supplying services which would otherwise have to be paid for. There is also an indirect saving which is brought about by the therapeutic effect of work upon the patients so engaged. The recovery of some patients is furthered so that they are discharged or paroled, in either of which cases they cease to be an expense to the hospital. Other patients who are not sufficiently helped to warrant their discharge are made less destructive and require less care. Partially offsetting this is the fact that many employees are required to direct and guide the activities of the patients.

C. *Principles Governing the Utilization of Patients in Hospital Industries and Occupational Classes*

There are certain principles that should be followed if the hospitals are to utilize patient labor to reduce operating expenses.

First, it should always be borne in mind that the hospitals are intended to cure or benefit the patients. This consideration should always determine whether a patient should be employed or not, and in what manner he should be employed. This has not always been the case in the past.[9] In a number of cases the saleability of the product has been put foremost rather than the benefit which might be rendered the patient. Because this has been so there has been a tendency among those who are keenly interested in developing occupational therapy as a means of aiding the individual patient to go to the other extreme and say that nothing but the needs of the patient should be considered.

This is just as bad as to ignore the welfare of the patients. The second principle is that, while always suiting the patient's activities to his needs, that one of several occupations for which he is suited should be chosen which will be most profitable for the hospital. To carry this principle into effect requires long study of the occupations for which patients are suited.

In New York the bureau of occupational therapy has been doing this. Fortunately, before the establishment of the bureau in 1921 there was already available a sizeable stock of information as to the employment of patients in the hospital industries. It had already been observed that farm work was particularly beneficial to patients and large numbers of patients were very profitably engaged in such work where they were able to benefit themselves and render a valuable contribution to the maintenance of the hospitals.[10] Improved patients were also employed to very good advantage in the tailor and shoe shops and in the great variety of tasks connected with running the institution. But these patients were only the willing workers, the more improved patients in many cases, for whom this sort of work was often an indication that they could soon be discharged.[11] These

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[9] Potter, C. A., *op. cit.*

[10] See B. Malzberg, *A Statistical Review of Occupational Therapy in the New York Civil State Hospitals.*

[11] Fordyce, O. O., *Occupational and Recreational Therapy for Mental Patients.*

patients were assigned tasks where their work was definitely helpful to the running of the hospitals. Their work helped to cut the cost of maintaining the hospitals at the same time that it tended to improve the patients' mental attitudes.

It remained for the present decade to see a concerted attempt to extend the benefits of occupational therapy to others than those who could be interested in working without the exercise of too much persuasion.[12] In this time all of the activities shown in the chart opposite page 73 have been developed, except for a few previous sporadic attempts. Under the guidance of Mrs. E. C. Slagle, who has been director of the bureau since its inception, the principal stress has always been laid upon the development of techniques designed to be of the greatest benefit to the individual patient. Now that the bureau is firmly established and the former tendency to judge all occupational work by the economic value of the products has been displaced by a recognition of the needs of the patients, more attention is being given to the desirability of selecting occupations for class work which produce articles of value either for use in the hospitals or to be sold. Thus the making of cement blocks and posts and block printing have been taught, first, because they have been found to be suited to the needs of the patients, and second, because the products may be utilized to good advantage in the hospitals. The same is true concerning the making of willow furniture. This industry has grown rapidly in the pre-industrial shops of some of the hospitals. It not only occupies a large number of patients in a variety of ways which are beneficial to them but it is providing the hospitals with much well made and necessary furniture.[13] Furthermore the bureau is continually studying the advisability of teaching other occupations, although for the time being it is concentrating on perfecting and standardizing a few which have been found to be especially good for the patients.

A third principle is that hospital sites should be selected, hospitals should be built, and equipment should be bought with the need in mind of providing the fullest degree of opportunity

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[12] Malzberg, *op. cit.*

[13] See, especially, the report of the director of occupational therapy in the *Thirty-ninth Annual Report of the Department of Mental Hygiene*, pp. 95–97.

for patients to engage in useful occupations. This has not been followed in choosing some of the locations for the present state hospitals in New York. To be more exact, conditions have changed so much since the sites were selected that they are not now suitable. Thus, for instance, the Manhattan State Hospital on Ward's Island, with over six thousand patients, has almost no place for them to be occupied out of doors in the most beneficial activities. Added to this is the fact that it is exceedingly wasteful to use such valuable land for the care of the insane. Several of the other state hospitals are similar to the Manhattan State Hospital in this respect, but to a less degree. On the other hand the new institutions recently built or started by the department have all been placed in carefully chosen sites suitable for agricultural operations. The plans also provide for adequate workshops for the patients.[14]

It is also true that with very few exceptions all of the old state hospitals have extremely inadequate facilities for classes in occupational therapy. This situation has been remedied to a fair degree in the last few years and is constantly being improved.

The same is true with respect to equipment. The advocates of occupational therapy have been in the position of having to convince the legislature of the desirability of their projects at the same time that the absence of funds made it difficult for them to show how desirable their work is. This difficulty has been largely overcome and expansion of their activities is going forward as quickly as they can be organized.[15]

Fourth, worth while work should be provided for every patient who is capable of engaging in it. In the New York state hospitals this principle is followed so far as the employment of the obviously capable patients is concerned. Indeed, there is constant pressure upon the ward physicians to assign more patients for work on the farms, in the laundry, etc. If anything, there are more jobs available for capable patients than there are patients to take them. It is with respect to the less capable

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[14] *Psychiatric Quarterly Supplement*, April, 1929, pp. 72–73, and the *Thirty-seventh Annual Report of the State Hospital Commission*, p. 17.

[15] See the annual reports of the director of occupational therapy, printed in the *Annual Reports of the Department.*

patients that more can be done. As has already been pointed out in another respect, the work with this class of patients is steadily expanding. But this is less important from an economic point of view than from a therapeutic standpoint. The greatest saving to the hospitals comes from the work of the capable patients who are employed in the major hospital industries. Whatever economies result from the employment of other patients are due not so much to the value of their products as to the resulting need for less expensive care.

Fifth, incentives should be established to encourage patients to work. Physical incapacity to work is found among a large proportion of insane persons,[16] but it is only one of the obstacles to complete industrialization of the hospital population. Lack of ability to concentrate, delusions as to ability to work, and plain unwillingness are at least of equal importance. Patients who lack ability to concentrate can sometimes have their condition improved by intensive supervision and guidance in occupational classes. The same is true of those who believe themselves incapable of work when in reality their incapacity is wholly mental.[17] It is more difficult, however, to get patients to work when they are unwilling to do so. In these cases there is need for some incentive to spur the patient to do something more than sit about the wards in complete idleness.

Experience in occupational classes has shown that it is a real incentive to some patients to know that the work which they do has some economic value.[18] Some, of course, are so deteriorated that they can do nothing of direct economic value, but this is not true of most of the patients. So in the interest of therapy as well as economy, the occupational therapists attempt to have their classes produce articles of value.

Again, it is useful to appeal to the aesthetic sense of many patients. Bright colored materials are generally more pleasant to work with than dull ones. Many of the articles produced

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[16] Variously estimated, but in the neighborhood of 20 per cent.

[17] *Cf.* Putnam, *op. cit.*, and annual reports of the director of occupational therapy.

[18] Garvin, M. M., *Crossroads in Occupational Therapy*, and *Annual Report of the Trustees of the Gardner State Colony*, 1927, p. 5.

in the more advanced occupational therapy classes are quite artistic and for that reason appeal to many of the patients.[19]

The greatest incentive is the fact which is impressed upon the patients that their work is an essential and important part of their treatment. It is unfortunately true that it is almost impossible to devise a means of rewarding patients who do good work more directly than they are now rewarded. Since most of the patients are maintained at the expense of the state it seems only fair that when they are able to work for their care they should do so.[20] As a matter of fact there appear to be very few patients the value of whose work equals the cost of their care. Occasionally, however, a skilled workman is admitted to the hospitals who is able and willing to perform very valuable services for the hospital.[21] Patients of this sort should be credited with what they earn above the cost of maintenance, or with all that they earn if their care is already paid for. In some of these instances the patient does not become an asset to the institution until he is nearly fit to be discharged. Frequently it is possible to take such a patient on as a paid employee before it would be considered advisable to authorize his discharge if no provision were made for his later support. This is usually possible because there is invariably a high rate of turnover among hospital employees and vacancies are common.[22]

When patients do good work but not work of sufficient value to warrant their being paid it is possible to reward them with special outings or occasional special refreshments. It is sometimes possible to reward individuals with special privileges or special clothing but this is likely to lead to jealousies which make satisfactory adjustments of this kind difficult.[23]

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[19] *Ibid.*

[20] Pollock, H. M., *The Financial Side of Occupational Therapy in State Hospitals.*

[21] Such a patient was at the Hudson River State Hospital for a few weeks in 1929 during which time he was constantly engaged in making a number of very important repairs to hospital machinery.

[22] On June 30, 1928, the state hospitals employed 8,656 persons, but during the previous year 5,794 had been engaged and 5,490 had left the service. This condition is somewhat improved at present.

[23] Pollock, H. M., *The Financial Side of Occupational Therapy in State Hospitals.*

Sixth, as has been pointed out by Dr. Pollock,

"Definite records of investment, expenses, output and income should be kept as well as adequate statistical records of patients receiving treatment."[24]

When such records are available it will be much easier to demonstrate the value of the work than now when reports stress principally the numbers of patients who are receiving class instruction and say almost nothing about expenses, income or profits.

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[24] *Ibid.*, p. 190.

V

The Financial Aspects of Insanity Prevention and of the Early Discharge or Parole of Patients

A. *The Theoretically Possible Ways of Curtailing Expenditures for the Care of the Insane*

The total amount which the state spends in any one year for the care of the insane can be treated as the product of two sums, namely, the daily average number of patients under treatment and the annual expenditure per patient. The size of the daily average patient population depends in turn upon the number of patients admitted to the hospitals and the average duration of their stay there.

Several factors influence the size of the annual expenditure per patient. Among the more important of these are the amount and quality of food and clothing furnished the patients, the number and efficiency of the employees who care for them, and the extent to which the patients are engaged in useful pursuits which tend to curtail the value of the articles and services which must be paid for by the state. The last of these three factors has already been discussed in chapter four, while the others do not fall within the immediate scope of this thesis.[1]

The second factor in making total expenditures for the care of the insane as great as they are is the size of the daily average patient population. This, as has been seen, depends upon the number of admissions and the duration of their hospital life. Here, theoretically, there should be two possibilities of reducing the number of patients cared for at any one time. Thus if the

[1] Within the last year the Department has found it necessary to increase the per diem allowance for patients' food. It has also been necessary within the last few years to increase the salary and wage scale of officers and employees generally because the former rates were so low that the personnel required to maintain the hospitals at a desirable state of effectiveness could not be secured or retained in the hospital service. (See note 23 on page 199 as to labor turnover in the hospitals.) Since the bulk of expenditures for the operation of the hospitals are for food and personal services (See the annual reports of the Department), it is unlikely that the annual expenditure per patient can be reduced without serious detriment to the effectiveness of the hospitals.

number of patients who must be admitted to the hospitals can be diminished or if the average duration of a patient's hospital life can be diminished, the daily average patient population would be proportionately reduced. Then, unless the per capita cost of providing for the patient's care has been greatly increased, the total cost of state care would be reduced.

It is the purpose of this chapter to analyze these two possibilities so as to determine whether they offer any means of reducing or keeping down the cost of providing for the insane. To do this it is necessary to consider the following things:

1. The extent of present knowledge as to the causes and prevention of the various psychoses.
2. The known means of facilitating the early removal of patients from the hospitals.
3. The possibility of discovering new ways to prevent insanity or to facilitate the removal of patients from the hospitals.
4. The relation between what these activities will cost the state and what it would cost the state to care for the insane if these activities were neglected.

B. *Prevention. The Psychoses, their Causes and Known Means of Prevention and Retardation*

Table IX shows the first admissions to the New York state hospitals for the period from 1921 to 1928, classified according to psychoses. Of these psychoses the first twelve are due to organic changes or toxic conditions. The remainder are functional psychoses. The causes of the former are fairly well known whereas the etiology of the latter is very questionable and the possibility of prevention correspondingly doubtful.

If the size of the patient population of the state hospitals is to be controlled by decreasing the numbers of patients proper to be admitted it must be as the result of measures taken to prevent specific types of mental disease. With present day knowledge there is a possibility of noticeably decreasing admissions in six of the categories of organic mental diseases, which in 1928 contributed 20.5 per cent of the first admissions.

The first of these are the traumatic cases. About three-fourths of these are directly due to head injuries. The number

TABLE IX

DISTRIBUTION OF PSYCHOSES OF FIRST ADMISSIONS TO NEW YORK STATE HOSPITALS FOR THE INSANE, YEARS ENDING JUNE 30*

	1921	1922	1923	1924	1925	1926	1927	1928
Traumatic	20	18	22	31	41	43	50	57
Senile	637	696	737	677	756	756	773	902
With cerebral arteriosclerosis	542	599	605	675	737	866	978	1,020
General paralysis	827	840	813	822	811	811	822	926
With cerebral syphilis	38	56	56	49	57	55	55	62
With Huntington's chorea	23	9	12	9	10	15	9	11
With brain tumor	14	13	9	10	15	14	20	9
With other brain or nervous diseases	43	54	85	77	109	102	114	120
Alcoholic	193	226	276	373	422	422	554	509
Due to drugs and other exogenous toxins	29	32	27	23	34	16	31	27
With pellagra		1	1	5	3	1	1	2
With other somatic diseases	145	158	183	170	188	180	174	188
Manic-depressive	989	1,055	977	1,002	1,050	995	1,070	1,196
Involution Melancholia	262	276	235	231	227	223	240	258
Dementia praecox	2,049	1,830	1,811	1,913	2,058	1,946	2,149	2,326
Paranoa or paranoic conditions	113	101	87	79	78	72	64	82
Epileptic psychoses	198	178	153	116	162	133	162	165
Psychoneuroses and neuroses	135	113	108	89	111	116	123	145
With psychopathic personality	182	189	173	142	127	121	144	158
With Mental deficiency	182	179	183	171	201	195	186	230
Undiagnosed	261	327	288	202	189	157	149	145
Without psychosis	57	65	59	67	49	56	62	76
Totals	6,939	7,015	6,900	6,933	7,435	7,295	7,928	8,614

* Compiled from tables in the annual reports of the State Hospital Commission and the Department of Mental Hygiene.

of these has been steadily increasing for the last seven years as shown in Table IX. It is problematical whether with the constantly increasing numbers of automobiles and the industrialization of the state the number of these cases can be reduced,

but it is evident that the present trend shows the desirability of safety first campaigns and regulations which tend to reduce the number of accidents.

General paralysis and psychoses with cerebral syphilis may be considered together as both are caused by syphilis. There is at present a greater possibility of preventing these cases than any of the other organic psychoses.[2] As Table IX shows, the number of patients admitted with these psychoses has been almost constant from 1921 to 1927 but in 1928 there was an unprecedented number of cases of paresis. It is suggested that this increase is attributable to the recent discovery of new methods of treating this disease. Whereas, previously this disease was almost invariably fatal within a year or two of a patient's commitment, complete remissions or improvement are now common and the death of patients is postponed in most cases.[3] It is believed that knowledge of this fact is leading many patients to seek commitment for treatment who would formerly have stayed out of the hospitals until the most advanced stages of the disease.

In 1928 syphilis was considered to be the cause of mental disease among 12.3 per cent of the first admissions to the New York state hospitals.[4] With present day knowledge of the treatment of syphilis practically all of these cases can be prevented from developing to the point where hospital care is required.[5] If this is to be accomplished, however, several things must be done. In the first place, there is need for more publicity in respect to the dangerous character of syphilis, and especially in respect to the need for thorough treatment in the early stages of the disease. In the second place, clinics should be made available everywhere for the treatment of syphilis so as to get as many cases as possible under control in the early stages. It is especially important to give anti-paretic treatment to persons

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[2] *Cf.* Sachs, *The Prevention of Mental and Nervous Diseases*; Brown, *Preventive Work Undertaken During the Year and Future Plans*; Hinsie, *The Influence of General Paralysis on the Family.*

[3] *Cf.* Hinsie, *Malarial Treatment of Female Patients with General Paralysis*; Kirby, *Tryparsamide Treatment of General Paralysis.*

[4] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 176.

[5] *Cf.* references in note 2.

where the likelihood of general paralysis developing is great.[6] It has also been pointed out that the routine examination of all near relatives of patients with general paralysis discloses a great many cases without apparent symptoms where treatment is called for. Such examinations should be made.[7]

While syphilis was the cause of the mental illness of 12.3 per cent of the patients admitted to the hospitals during 1928, only 4.6 per cent of the patients on the books of the hospitals June 30, 1928, had general paralysis or cerebral syphilis.[8] Nevertheless the cost of caring for this group of patients is probably nearly 10 per cent of the total cost of the state hospitals because of the high cost of commitment proceedings and the fact that these patients require unusually expensive treatment and have very little productive capacity. Hence it would appear that the syphilitic patients in the state hospitals cost the state between two and two and a half million dollars a year.

The vastness of this expenditure emphasizes the need for preventive measures. Such measures should be taken anyway from a public health standpoint but their necessity is made more apparent when it is realized that failure to take them will cost the state millions of dollars annually. The expenditure of a few hundred thousand dollars to provide clinics and to impress upon everyone the need for early treatment of the disease should soon make the development of general paralysis a rare event. The resulting saving would be much greater than the expense.

How much can be done to prevent the alcoholic psychoses is questionable. In 1909 10.8 per cent of the first admissions were of this type. From then until 1914 there was a steady decrease

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[6] Hinsie, *The Influence of General Paralysis on the Family*, pp. 96–97.
[7] *Ibid.*
[8] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 185. The difference between the percentage of first admissions with this disease and the percentage of the hospital population suffering from it is explained by the fact that the mortality rate of patients with general paralysis is so much higher than that of patients with most other psychoses. Whether the new methods of treating general paralysis will alter this situation materially cannot yet be told. These new methods result in the discharge of many patients who would otherwise have remained in the hospitals until death but they also cause many other patients to remain alive and in the hospitals longer than they would otherwise.

until in the latter year only 5.6 per cent were in this class. The next two years the percentage increased but after that it fell until 1920 when only 1.9 per cent of the first admissions had alcoholic psychoses. After that there was a steady increase in the number of this type of patients and in the percentage of all first admissions who were of this type. The new high point was reached in 1927 when 7.0 per cent of the first admissions were alcoholic. In 1928 there was another drop to 5.9 per cent.[9]

The interpretation of these statistics is difficult. The decrease in the number of commitments of alcoholic patients between 1909 and 1914 may have been due to the spread of local option, publicity as to the danger of excessive drinking, or more temperate habits of the people. The very sharp decline in the number of these cases in 1920 is without doubt due to prohibition. At the time, state hospital authorities were very optimistic that a principal cause of insanity had been removed. However, the steady increase in this type of patients since then shows either that there are as many persons drinking to excess as formerly or else that they are drinking more toxic beverages.[10] In either case it is evident that prohibition has not resulted in the abolishment of this sort of psychoses. Whether the more temperate use of alcohol, or of less toxic alcohol, would follow the adoption of any other system of regulation of the liquor business is only a matter of opinion. With the failure of the prohibition law to prevent the incidence of alcoholic psychoses, the only means now available to diminish the number of cases of this sort is continued publicity as to the danger of the excessive use of alcohol.

In the group—psychoses due to drugs and other exogenous toxins—prevention is now carried almost to perfection. There are still occasional cases of lead, arsenic, or gas poisoning but the great majority of these cases are due to the use of drugs such as opium, bromides, chloral, etc.[11] Very few of these cases can be saved from hospitalization.

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[9] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 163.

[10] For the optimistic attitude common directly after the passage of the Eighteenth Amendment, *cf.*, *Bureau of the Census, Patients in Hospitals for Mental Disease*, 1923, p. 61.

[11] *Annual Reports of the Department of Mental Hygiene*, Table X.

Finally, it may be possible to diminish the number of psychoses with other somatic diseases. Prevention, in this case, depends upon the general perfection of medical facilities in the community. As medical skill in the treatment of somatic diseases becomes greater, it is to be expected that some of these cases will not develop mental symptoms.[12]

From what has been said about the prevention of these types of organic psychoses it will be evident that their prevention does not call for taking any measures which are not already called for in the interest of promoting the public health and welfare. The prevention and treatment of syphilis, protection against occupational diseases, the prevention of the use of habit-forming drugs, setting up the highest standards for the care of somatic diseases, etc., are all essential parts of a public health program.

Some parts of this program are now being pushed as far as is desirable. In so far as this is the case it is beyond doubt that as a bi-product many cases of insanity are prevented,—cases which would have cost the taxpayers of the states thousands of dollars had they been permitted to develop. The need for greater provision for the prevention and early treatment of syphilis is evident. There is also a slight possibility that a few more alcoholic psychoses may be preventable. Especially in respect to the prevention of syphilis it would appear that a wisely planned program of prevention would save the taxpayers of the state several times its cost.

There is little hope of reducing the number of patients with the other organic psychoses. Indeed there is every reason to believe that the two largest groups will continue to increase in size. Senile dementia and cerebral arteriosclerosis are both diseases of old age. As medical control of various diseases is extended and the average age of the population becomes greater it is to be expected that there will be more cases of these diseases. That this has been the case is well shown in Table IX. From a purely financial point of view the growth of these groups is not so serious as would be the growth of some of the other psychoses

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[12] *Cf.* Sachs., *op. cit.*, and Brown, *op. cit.*

whose victims have longer periods of hospital life to look forward to.[13]

The functional psychoses which, in 1928, constituted 52.9 per cent of the first admissions may be considered as a single group from the standpoint of prevention.[14] There is not enough definite knowledge of the causes of these diseases to make it possible to prescribe as definite measures for their prevention as for some of the organic psychoses. There are some psychiatrists who, to a greater or less degree, still attribute these diseases to hereditary influence. The more common view at present is that early environment and chance have more to do with their development than heredity.[15] It is agreed by nearly all psychiatrists that, whether heredity is an etiological factor or not, proper environment and training will do much to prevent or cure an attack of these psychoses. That being the case, the logical thing to do is to work to improve environmental conditions which cause or hasten the onset of these psychoses.[16] This might be particularly effective in preventing the development of psychoses among the foreign-born.

How can this be done? There is reason to believe that most functional psychoses have their roots planted in the environment to which children are subjected in the formative years of early childhood.[17] To improve these conditions it is necessary to

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[13] The average duration of hospital life of patients with these two psychoses are 1.2 and 1.6 years, respectively, while for dementia praecox patients it is 16.8 years. (*Fortieth Annual Report of the Department of Mental Hygiene.*)

[14] *Fortieth Annual Report of the Department of Mental Hygiene*, pp. 214–215.

[15] *Cf.* Sachs, *op. cit.*; Brill, *The Rôle of Psychoanalysis in the Prevention of Nervous and Mental Diseases*; Raynor, *Problems in the Prevention of the Functional Psychoses.*

[16] *Ibid.*, especially Sachs, p. 281. "It is much more to the point to assume that hereditary influences, if they exist, can be counteracted to a great extent, if not nullified, by a healthy environment."

[17] *Cf.* Sachs, *op. cit.*, Bellinger, *Inadequate Childhood Training a Factor in Mental Disease;* McCord, *The Relationship Between Mental Hygiene and the Educational System,*—"We know that during the pre-school years many of the most important behaviour patterns (stamped by parents, brothers, sisters and playmates) have been placed upon the child; if not later analyzed and discharged from his personality they constitute real handicaps throughout school and life." P. 371.

educate parents as to the necessity of providing the right sort of training for their children.[18]

Next to the home the school is the most important factor in building up a child's environment. It is desirable, therefore, that the teachers be familiar with principles of mental hygiene.[19]

Of course the great majority of children grow up to lead normal lives. At the same time there are many children who get into difficulties of one sort or another while they are still of school age. For these we now have child guidance clinics in which the child is examined for physical, mental and social defects and treatment prescribed according to the findings.[20] The proponents of these clinics claim that they are responsible for keeping large numbers of children from developing psychoses.[21] On the other hand it is beyond doubt that many of the children treated by these clinics for mild personality defects would have developed into normal channels without treatment.[22] It is difficult to say, therefore, just how much these clinics save the state by preventing the development of psychoses, but it is beyond question that they do save something in this way.[23]

There remains the question as to whether anything can be done to prevent the development in adults of psychoses which will require hospital care. The only methods of doing this which have been found useful are to disseminate widely information

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[18] See especially, Thom, *Parental Guidance*, "Notwithstanding the criticism that has been directed toward the home and parents, the fact remains that both will long continue to be dominating factors about which the physical, mental, and moral welfare of the child must necessarily develop . . ."

[19] Steckel, *Educational Work of the State Hospital.*

[20] Thom, *op. cit.*; McCord, *op. cit.*; Brown, *Preventive Work Undertaken During the Year and Future Plans.*

[21] *Cf. Proceedings of the Twelfth Annual Meeting of the Indiana Society for Mental Hygiene;* Sandy, *Mental Clinics in Relation to Crippled Children*, "Where mental clinics are well conducted and patronized, they constitute one of the best present day forces for prevention."

[22] As was pointed out in an interview with Dr. Parsons, Commissioner of Mental Hygiene in New York, we must bear in mind that many children have slight personality defects which they outgrow as they grow older without having been subjected to any formal treatment. It is illogical, therefore, to assume that all of the children who develop normally after attendance at a child guidance clinic do so develop because of that treatment.

[23] Although Dr. Parson's contention is correct, the large number of cases in which good results attend the work of the child guidance clinics indicates that their work does give a basis for the claims which are made for it.

as to the nature of mental disease and to provide an adequate number of consultative clinics where persons with mental difficulties may seek advice.[24] To make these clinics effective it is necessary that they be given wide publicity.[25] It is believed that they have been of substantial value in keeping patients from requiring hospital care.[26] Since every patient who requires hospital care costs the taxpayers several hundred dollars, it is obvious that the slight cost of this publicity and clinic service is well repaid if only a very few persons are kept out of the hospitals.

C. *Facilitating the Early Removal of Patients from the Hospitals*

It is just as important and economical to provide for the earliest possible removal of patients from the hospitals as it is to prevent the incidence of psychoses whenever possible. The discharge or parole of a patient depends upon two things, namely, improvement in the patient's condition, and the conditions surrounding his return to extra-institutional life. Since it is the function of the hospitals to bring about improvement in their patients' conditions whenever possible, this factor affecting the patient's discharge may be assumed to be taken care of.

It is not sufficient, however, merely to effect improvement in a patient's condition. It is usually necessary for the state to take additional precautions if the patient is to maintain his mental health subsequent to his discharge from the hospital. If a patient upon being discharged returns to the same conditions which were responsible for his original breakdown without being especially safeguarded there is a strong probability that he will suffer a relapse. On the other hand, if it is possible to modify

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[24] *Cf.*, Brown, *op. cit.*

[25] Steckel, *Educational Work of the State Hospital*, pp. 488–499. "It is interesting to note the steady increase in the number of visits to our outpatient clinics which has occurred since the beginning of our educational program. The monthly average of new cases attending the clinics was 12.4 in 1924, 18.1 in 1925, 21.75 in 1926, and 44 in the first eight months of 1927. If, as we believe, the clinic attendance is an indication of the amount of preventive work that we are able to accomplish, it seems to us these figures are quite suggestive of the value of our educational campaign in the matter of prevention.

[26] *Ibid.*

the surroundings or to influence the patient's reaction to them the likelihood of his having a relapse is considerably lessened.

It is possible to do this by means of clinics to which discharged and paroled patients may come for advice and by means of social workers who investigate the conditions to which such patients will return upon their release from the hospitals and who aid the patients to adjust themselves to their environment by giving them advice or assisting them in getting work or in any of many other ways which may be indicated in a particular situation.[27]

Paroling patients is a means of shortening the duration of hospital life of a great many patients who have not recovered sufficiently to warrant their immediate discharge from the hospital but who require a minimum of supervision. During the year ending June 30, 1928, the daily average number of patients on parole from the state hospitals was 3,812, which amounted to 8 per cent of the average daily population.[28] The effectiveness of a parole system upon such a large scale depends entirely upon having an adequate staff of social workers and enough clinics to keep in touch with the parolees.[29] The paroled patients are, however, no expense to the state during their period of parole, except as they require this small amount of supervision.

If the state were to discontinue holding these clinics and employing these social workers nearly all of the patients on parole and many who have been discharged would have to remain in the hospitals. Furthermore, this number would be augmented by the addition of many patients who have been aided by these facilities in the past. Thus it is altogether likely that the resident population of the state hospitals would be 4,000 greater than it is now. Such an addition to the hospital population would necessitate a capital outlay in the neighborhood of $16,000,000. It would also cost the state about one and one half million dollars a year for maintenance. The desirability of effecting such an immense saving is self-evident.

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[27] The histories of patients readmitted to hospitals for the insane frequently show that the family situation which precipitated the first breakdown was also responsible for the recurrence of the illness. In other cases economic difficulties play the same rôle.

[28] *Fortieth Annual Report of the Department of Mental Hygiene*, p. 149.

[29] Hoch, *The Parole System in Massachusetts;* Pollock, *The Development and Extension of the Parole System of the New York State Hospitals.*

A system somewhat similar to parole which has been frequently advocated and successfully tried on a small scale is to segregate mild chronic cases and convalescents in cottages separate from the hospitals. These cottages can be of cheaper construction than the hospitals. Therein the patients can be maintained at a minimum cost and can be engaged in farming or industrial occupations to nearly offset the cost of their care. The principal objection to this plan on economic grounds is that the patients who can be thus removed from the hospitals are the ones who are now most valuable in performing hospital tasks. On the whole it is not likely that this plan offers any real economies, whatever other advantages it may have.[30]

D. *New York Activities to Prevent Insanity and to Facilitate the Early Removal of Patients from the Hospitals*

To a greater or less degree New York is using all the above-described methods to diminish the size of the hospital population.

Provision for facilitating the early discharge of patients is most complete. For this purpose the state is divided into as many districts as there are state hospitals and each hospital conducts regular weekly clinics in each of the larger towns in its district. These clinics were established as a means of keeping in touch with paroled patients, who must report to the clinic monthly during the duration of their period of parole. They are also open to anyone else seeking advice as to his own mental problems or those of his relatives or friends.[31]

In addition to the state hospital clinics which are chiefly for adults, the Department of Mental Hygiene conducts child guidance clinics wherever the need is reported. In the larger cities these are held regularly once a month, in rural communities less frequently. A total of nearly one hundred and fifty towns in the state have clinic service of this sort. The Department does

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[30] Cheney, *Are Colonies Practicable in the Care of the Insane?*

[31] Of the 23,447 visits to these clinics in 1928, 16,518 were made by paroled patients, 693 by discharged patients, and 6,236 by others. (*Fortieth Annual Report of the Department of Mental Hygiene.*)

not hold clinics in the largest cities of the state because these have other facilities for accomplishing the same purpose.[32]

The New York State Committee on Mental Hygiene has recently published a survey of mental clinic facilities in the state from which they concluded that every large village and city in the state was receiving some mental hygiene service but that (a) the state hospital clinics gave insufficient time to individual examinations and had inadequate provision for following up their recommendations; (b) the child guidance clinics lacked psychiatric social workers, depended too much on untrained workers to carry out the follow-up, and that each field agent had too large a territory to cover to devote sufficient time to training local agencies.[33] Since this report was published the number of field agents has been increased from six to nine. Also, the first criticism does not seem entirely warranted. The hospital clinics do give less time per patient to their visitors but the bulk of those who consult these clinics are paroled patients, whose case histories are already familiar to the clinician.[34]

Through these two types of clinics the state is making available to all who seek their services an opportunity to take advantage of all the means that are now known of preventing the development of psychoses. But if these clinics are to completely fulfill their purpose it is necessary that the people who could profit from them be made aware of their existence and of what they have to offer. The Department is carrying on a constant campaign to spread this knowledge.[35]

The Department is also trying to spread the knowledge of mental hygiene principles to all persons to whom they will be of use. As has been pointed out above, the place where knowledge of these principles is most needed is among parents and teachers.[36] For this reason, members of the Department and of the staffs of the state hospitals are giving a great number of lectures on

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[32] Branham, *An Inventory of Mental Clinic Facilities of New York State Exclusive of New York City.*

[33] *Ibid.*, p. 436.

[34] *Cf. supra*, note 31.

[35] *Cf.*, Brown, *op. cit.*; Steckel, *op. cit.*, and note 25 above.

[36] See especially Steckel, *op. cit.*, and McCord, *op. cit.*, and notes 17 and 18 above.

associated topics to parent-teacher associations, teacher training classes, service clubs, women's clubs, and a number of similar organizations.[37]

E. *The Cost of These Measures v. The Resulting Economies*

The amount which these activities save the state is immense. The state hospital clinics, for instance, by the most liberal computation cost the state $236,400.00 in the year ending June 30, 1928.[38] If this amount and the amount which reimbursing patients paid the state that year are deducted from the total disbursements for maintaining the hospitals, $15,506,037.18 is left as the net cost of caring for the 43,693 patients who constituted the daily average population of the hospitals.[39] This makes the cost per year per resident patient approximately $355.00, or the cost per month, $29.58. But by dividing the cost of the clinics by the daily average number of patients on parole we find that the cost of the clinics per patient paroled was only $62.01 in the year ending June 30, 1928. Thus the expense of maintaining these clinics would be more than saved to the state if they were the means of keeping the average paroled patient out of the hospitals as much as two and one-tenth months. Nor does this make any allowance for the interest on the immense outlay which would be necessary to house and care for all of these patients. There is every reason to believe that these clinics save the state several times what they cost.

These same state hospital clinics also were consulted 693 times in 1928 by discharged patients and 6,236 times by others,

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[37] Steckel, *op. cit.* Also Hill, *Teaching as a Function of the State Hospital*, in which he advocates courses for the staff, the social service, and the ward service of the hospital, "to stimulate a broad catholic interest in the psychiatric way of looking at human affairs."

[38] Computed as follows: The clinics took 1,343 days. Allowing an equal amount of time for studying and formulating reports, etc., this would require the full time of nine physicians. The maximum salary of the grade of psychiatrists who attend these clinics is $3,200.00. Physicians' services then amount to $28,800. There are 39 social workers who receive maximum salaries of $1800, and approximately 16 stenographers whose maximum salary is $1200, making these two items $70,200 and $19,200, respectively. Allowing an amount for expenses equal to the item for salaries makes the total expense of the clinics and the social work $236,400 in the year ending June 30, 1928.

[39] Computed from statistics in the *Fortieth Annual Report of the Department of Mental Hygiene.*

in addition to the visits of paroled patients.[40] It is most probable that many of these persons were benefitted by their consultations sufficiently to prevent their becoming inmates of the state hospitals. The social workers also made 566 visits on behalf of preventive cases, and found 13 situations for persons of this sort.[41]

Child guidance clinics as means of preventing the development of advanced psychoses are still in the experimental stage. It will be several years before enough data is at hand to show whether they are profitable from a purely financial point of view. On the other hand, they have already shown themselves to be justified by their social results and will undoubtedly be continued and developed for that reason. Therefore, it is not wrong to consider that any cases of insanity which are prevented by them and the saving to the state which results therefrom is pure gain.

The expense which can be charged against the publicity campaign which is being carried on by the Department of Mental Hygiene is also insignificant. The leaflets which the Department distributes in large numbers cost only a few hundred dollars a year. The bulk of this work is performed by the various officials of the Department and of the state hospitals who carry on this work in addition to their regular duties.

The question remains, should the state spend more for prevention than at present, and would greater expenditures be repaid by greater savings? From what has already been said it is evident that not enough is known about the causes of mental disease to warrant the state in hoping for much better results than it is now getting, except in connection with the prevention of syphilis and general paralysis. On the other hand it would appear that the state would be justified in conforming its practices to meet the two main criticisms of the State Committee on Mental Hygiene, namely, that more adequate provision should be made for following up the recommendations of the state hospital clinics, and that the child guidance clinics should be furnished

[40] *Ibid.*, p. 67.
[41] *Ibid.*, p. 71.

with psychiatric social workers, as is the case in the best organized clinics of this kind, instead of relying so largely upon the assistance of untrained agencies. Whether these added expenditures would pay for themselves in terms of reduced expenses for the maintenance of the state hospitals is doubtful but they would be likely to pay for themselves in other ways.

F. *Expenditures for Research*

It has been pointed out that wise expenditures to take advantage of existing knowledge of measures designed to prevent the development of insanity or to facilitate the early removal of patients from the hospitals are very effective means of saving money for the taxpayers of the state. Greater savings than these, however, are to be hoped for as the result of still unmade discoveries of new methods of preventing and treating mental illnesses.

The fact that within the last few years such discoveries have been made which are of revolutionary effect upon the manner of treating and preventing two of the psychoses about which almost nothing was formerly known makes this hope seem tangible.

Only a relatively few years ago general paralysis was known as an incurable disease from which a patient would probably die within two years of his admission to a state hospital. Then, through painstaking research, it was discovered that the disease was caused by syphilis. A few more years of research developed techniques by which it is possible to prevent the development of most cases of general paralysis and to cure or greatly improve a majority of those which are not prevented.

Likewise, the cause of pellagra has recently been discovered so that this disease about which nothing was known until lately may now be prevented and cured if prompt measures are taken. Unlike general paralysis, there are few cases of this disease in New York so that knowledge concerning it will not save that state the great sums which will be saved the states where it is more common.

When it is realized that so much has been learned within such a short time about the causes and means of curing two types of

psychoses which were so recently absolutely hopeless diseases, the possibilities and desirability of research into the nature of the other less known psychoses is evident. When the millions of dollars which the state spends to care for the victims of these unknown diseases is considered, such research seems not only desirable for its social value but also from the purely financial point of view that it may be expected to yield the state heavy dividends in the future in the way of reduced expenditures for the care of the insane.

New York is now doing all that it could be expected to to further such research. The members of the state hospital staffs are encouraged to make independent studies and nearly every hospital has a pathologist on its staff. This means the constant accumulation and sifting of an immense amount of data.

In addition to the work of the hospital physicians the state maintains two institutions devoted to research and instruction in psychiatry. One of these, the Psychiatric Institute in New York City, has been in existence for a number of years and has done valuable experimental and instructional work. This Institute has recently been installed in new quarters in conjunction with the Columbia University-Presbyterian Hospital Medical Center. The other is a new but similar institution in connection with Syracuse University.

These Institutes provide care for only a few hundred patients and the per capita cost is very great as compared with the cost of maintenance in the other state hospitals but when it is realized that these payments are but the necessary premiums which must be paid to protect the taxpayers of the state against the necessity of ever-increasing taxes for the care of the insane, they appear insignificant.

G. *Summary*

From a financial point of view the following conclusions stand out as important:

1. That by taking certain inexpensive measures the state can prevent the development of enough cases of mental disease to save itself millions of dollars over and above what it spends for prevention. With the present limited knowledge of the

nature, causes and treatment of the psychoses the state is doing nearly all that seems wise except that:

(a) Much more could be done, with great profit, to prevent the psychoses arising from syphilis.

(b) There is some reason to believe that a slightly larger personnel to conduct child guidance clinics would result in economies sufficient to offset the cost.

2. Similarly, the state can, and now does, save itself millions of dollars a year by providing inexpensive supervision for paroled patients. Here again, a slight extension of this work might prove to be economical.

3. Above all, the economy of seeking for new knowledge concerning mental diseases is pointed to. It would appear that this present expenditure would pay for itself many times over in the future.

All three of these measures call for the expenditure of thousands of the taxpayers' dollars every year but each of them is desirable because it will save the state many times its cost.

VI

Conclusions

This study of the financial aspects of state care of the insane in New York has been based upon these considerations:

1. That state care of the insane is an essential function of the state.

2. That this places a heavy burden upon the taxpayers of the state.

3. That, therefore, the interests of the taxpayers should be considered and safeguarded in planning a policy for the care of the insane.

The interests of the taxpayers require that, considering the care of the insane as a state function which must be carried on year after year instead of as merely the concern of any one fiscal year, every means consistent with the proper treatment of mental illnesses should be utilized to minimize the total amount of taxes needed for this purpose. It is particularly important that the continuing need for these expenditures be stressed for upon this depends the wisdom of some of the present expenditures.

It was found that, in addition to the ordinary principles of administration which are as applicable in this field as elsewhere, there are four outstanding methods of curtailing the amount of taxes which must be devoted to this work. These are:

1. The collection from the estates of patients and from their relatives responsible for their care of sums to reimburse the state for its expenditures on their behalf. These persons, rather than the taxpayers, should be primarily responsible for the cost of patients' care. Reimbursement should not be collected in any case, however, when payment would have the effect of pauperizing the patient's relatives. To effect the greatest saving to the taxpayers from this source, the following principles should be applied:

   (a) The ability of the persons liable for a patient's care, after making due allowance for their needs and for those of any other dependents, should be the chief measure of

the amount of reimbursement required. Those who can afford to pay the rates charged by private institutions for the care of the insane should be charged rates comparable to those charged by such institutions, because the state hospitals are intended primarily to care for those who cannot provide for their own care.

(b) Investigation as to the possibility of collecting reimbursement should be in the hands of a few agents who devote their entire time to this work.

(c) When a patient's relatives are found to be liable for his support and able to pay, appeals to their pride to keep their relative from being classed as a pauper are preferable to insisting upon payment as a legal obligation, because it is very difficult and expensive to enforce the legal obligation.

(d) It is profitable to make the same sort of appeal to persons who are not legally liable for a patient's support but who may prefer to pay rather than have their relative or friend classed as a pauper.

(e) Reexamination of ability to pay should be made when payments are in arrears, when relief from payment is sought, or when there is any reason to believe that a patient or his relatives are liable for greater payments than they are making.

In New York the application of these rules saves the taxpayers about one and three-fourths million dollars a year. It would appear, however, that somewhat more attention to the possibility of reassessing persons' ability to pay would be profitable.

2. The removal to the proper jurisdiction of aliens and citizens of other states for whose care the taxpayers of New York have no responsibility, and taking such measures as are within the power of the state to keep out such persons as are likely to become public charges. There are so many insane persons of these classes in New York that their removal requires the services of a special bureau in the Department of Mental Hygiene. The work of this bureau saves the taxpayers of the state several hundred thousand dollars a year above what it costs.

It was also shown in this connection that the prevalence of insanity among the foreign-born residents of the state indicates

the desirability of selective immigration laws and the failure of immigration laws in the past to keep out thousands of aliens who have become public charges because of insanity. Recent federal laws tend to improve this situation but it is still believed by the New York officials in charge of this work that greater federal appropriations to sift out undesirable aliens would save the state several times the cost to the nation.

3. The direction of each patient's abilities into channels which will produce articles of value to the hospitals or which will make it unnecessary to purchase articles or services which would otherwise have to be paid for with money raised by taxation.

To secure the utmost saving from this source without detriment to the welfare of the patients the following rules should be observed:

(a) Each patient should be assigned to work which is suitable in view of his mental and physical condition. Proper occupations are among the most important therapeutic agencies in the treatment of mental diseases, but care must be used to select suitable occupations for patients. Failure to observe this rule may result in a longer period of hospitalization for a patient which in turn will cost the state more than is saved by the patient's activities.

(b) When several occupations are equally suited to a patient's needs he should be engaged in that one where he can be most profitably employed.

(c) In choosing hospital sites and in building and equipping the hospitals the fullest provision should be made for patients to engage in useful occupations.

(d) Incentive should be furnished to encourage patients to do good work. In the rare cases when the value of a patient's work exceeds the cost of his care and treatment he should be paid the difference. In other cases other incentives should be furnished.

(e) Definite records of investment, expenses, output and income from the work of patients should be kept as a means of determining the value of different kinds of work and to make for more efficient methods.

To the extent that these principles are applied in the New York state hospitals they are saving the taxpayers of the state at least a million dollars a year and probably two or three times that amount. At present there is an almost total absence of definite records of the value of the work. The suggestion in paragraph (e) above should be carried out. Also, some of the older hospitals make entirely inadequate provision for the employment of patients in the most profitable lines for which they are fitted. The Department of Mental Hygiene is now fully aware of the importance of this work, however, and is constantly working to improve the situation.

4. Taking measures to minimize the number of patients who must be cared for at any one time. In this respect the expenditure of moderate sums is saving the state millions of dollars. These expenditures should be made as follows:

(a) For clinics and the dissemination of knowledge as to what can be done to prevent mental diseases, so that preventive measures can be taken where and as called for.

(b) For clinics and social service workers to make it possible for the hospitals to discharge or parole patients as soon as they can get along with a minimum amount of supervision.

The cost of neither of these types of work is in any way comparable with the savings which they make possible.

(c) For scientific research, so that the present day limited knowledge of means of preventing and treating mental illnesses may be extended. This should result in immense savings to the taxpayers of the future.

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